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AUTHOR King, Martha P.
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ABSTRACT

Millions of American children and youth, especially low-income and minority children, lack health insurance and access to appropriate health care services. This publication addresses several major public policy topics related to improving children's health, and is designed to serve as a resource for policymakers who want to improve access to quality health care services for children. Each of the publication's six sections covers a specific topic and highlights existing state programs to illustrate a variety of approaches to common issues. The first section focuses on the millions of American children without health insurance coverage, and the second section looks at ways to bring Medicaid services to more eligible children. Special health care needs, such as chronic illness or severe impairment, are discussed in the third section. The fourth section examines the reasons for, and ways to improve, poor immunization rates in the United States. Basic adolescent health care services and services relating to sexual activity, substance abuse, accidents, and violence are covered in the fifth section. The last section highlights three health care issues: access to care by minorities, early intervention for high-risk families, and emergency medical services for children. Sixty-seven notes, a glossary of abbreviations, and a list of organizations that can supply further information are included. An annotated bibliography cites 31 references. (TJQ)

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Healthy Kids!



State Initiatives to Improve Children's Health

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- To foster interstate communication and cooperation.
- To ensure states a strong cohesive voice in the federal system.

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Healthy Kids!

State Initiatives
to Improve
Children's Health

by

Martha P. King
Program Principal, Health Services Program

National Conference of State Legislatures

William T. Pound, Executive Director

1560 Broadway, Suite 700
Denver, Colorado 80202

444 North Capitol Street, N.W., Suite 515
Washington, D.C. 20001

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Executive Summary

Millions of American children and youth lack health insurance and access to appropriate health care services. Low-income and minority children make up a disproportionate share of the uninsured and those who have not received recommended screenings and immunizations. Children with special health care needs face additional access issues, especially related to insurance coverage for needed services.

This publication addresses several major public policy topics related to improving children's health, including providing insurance coverage for more low-income children, expanding and improving Medicaid programs, financing services for children with special health care needs, improving immunization rates, and addressing adolescent health issues. For each topic, highlights of state programs illustrate a variety of approaches to the common issues. The section "Other Strategic Issues" provides brief highlights of individual state efforts concerning minority health issues, early intervention services for high-risk families, and emergency medical services for children. Although many of the program highlights include brief information about other states with similar initiatives, this publication does not intend to list information about all existing programs. NCSL welcomes additional information about other states and their activities to improve children's health.

INSURANCE

About 9.5 million American children lack health insurance coverage. Approximately 70 percent of uninsured children live in families with incomes below twice the federal poverty level (FPL). A number of states sponsor initiatives to insure more children. A *Florida* pilot program provides health insurance coverage through the public schools. *Minnesota* sponsors a state program to insure low-income children. Several other states, including *New York*, *Pennsylvania*, *Connecticut*, *Hawaii*, and *Massachusetts*, subsidize private insurance coverage for low-income children. *Iowa* and 17 other states participate in the Caring Program for Children insurance initiative, which started in western *Pennsylvania*. At least 11 states require insurance plans to cover well-child care services, and a few states require courts to order health insurance coverage in divorce cases.

MEDICAID

As the number one insurer for low-income children, Medicaid finances health care services for approximately 13.5 million children and youth under age 18, and additional youth through age 20. Millions more children and youth may be eligible but are not enrolled due to program barriers or lack of knowledge about their eligibility. Even children covered under Medicaid may not receive appropriate screenings and services due to access barriers or lack of knowledge about appropriate services or where to seek them. Several states sponsor programs that cover more children than required under federal law or conduct outreach to enroll or provide services to more eligible children. *South Carolina* sponsors an outreach program under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT). *Vermont* expanded its Medicaid program to cover children up to age 18 with family incomes up to 225 percent of the federal poverty level. *Louisiana* conducts EPSDT screening services in nearly one-half of the state's public schools.

SPECIAL HEALTH CARE NEEDS

Between 10 percent and 15 percent of American children have a chronic health condition. One to 2 percent have severe impairments that require special medical and support services throughout their lives. Many families who have children with special health care needs face difficulties obtaining and keeping the comprehensive health care coverage necessary to meet those needs. In addition to Medicaid expansions that make the program a significant resource for low-income children with special health care needs, a few states sponsor programs that assist families with insurance coverage or catastrophic expenses. *Massachusetts* provides full or supplemental health care benefits to families who need such assistance. *New Jersey's* Catastrophic Illness in Children Relief Fund assists certain families with extraordinary health care expenses. *Michigan* and most other states provide a variety of support services to assist families in caring for their children.

IMMUNIZATION

An estimated 40 percent of American preschoolers are not fully immunized. Recent outbreaks of

vaccine-preventable diseases that cost lives, cause disabilities, and are expensive to treat underscore the public health need to improve immunization rates. High costs, inadequate insurance coverage or financial resources, overcrowded public clinics, and lack of parental awareness all contribute to poor immunization rates, especially among low-income children. *Rhode Island* and at least 14 other states purchase vaccines for free distribution to any state child. *Ohio* and at least 15 other states purchase vaccines to distribute free to Medicaid providers. A new *Colorado* law requires parents to have their infants immunized. *Oklahoma* spearheaded an aggressive public education and outreach campaign for childhood immunization. *North Carolina* protects vaccine manufacturers and health care providers who administer vaccines from vaccine-related injury claims.

ADOLESCENT HEALTH

About 16 percent of youth ages 13 to 17 lack health insurance. As with other uninsured children, a disproportionate share of uninsured adolescents are poor, members of a minority group, or both. Adolescents need basic health care services and also services to deal with a range of other issues that stem from risky behaviors, such as sexual activity, alcohol and other drug abuse, accidents, and violence. States address adolescent health care needs through a number of initiatives. *New Jersey* sponsors a range of services for high-risk adolescents through or near public secondary schools. *Georgia* targets federal block grant funds to communities that provide school-based or

community-based programs to address health and social services needs for youth. The *Maryland* Governor's Council on Adolescent Pregnancy sponsors a variety of efforts to reduce teen pregnancies.

OTHER STRATEGIC ISSUES

This publication briefly highlights three state programs that address other issues of concern to children's health and well-being: access to care by minorities (*Ohio*), early intervention for high-risk families (*Hawaii*), and emergency medical services for children (*New Jersey*).

CONCLUSION

Ideally, all children should have a "medical home" that provides continuity of care and coordination among services and service providers. Linkages should exist to other health and social services to help ensure children's well-being. States struggle to improve access to quality health care for children, while facing major budget constraints. This publication intends to serve as a resource for policymakers who want to improve access to quality health care services for children.

RESOURCES FOR FURTHER INFORMATION

The resource list in the appendix and the annotated bibliography list organizations and publications that provide additional information about the topics discussed in this publication.

Introduction

States placed much emphasis over the past several years on improving birth outcomes. Good prenatal care means more healthy babies. Although much work remains, states deserve credit for their efforts to reduce low birthweight and infant mortality rates.*

Until recently, not much public attention focused on keeping babies healthy and promoting their successful development into healthy children, youth, and young adults. Access to appropriate, timely, and comprehensive health care services plays a key role in producing a healthy generation of children. Ideally, all children should have a "medical home" where they receive comprehensive services from health care providers who offer continuity of care. In addition, health services should be coordinated with social, physical, mental, and intellectual needs in children's development.

Millions of U.S. children lack health insurance and access to health care services. Low-income and minority children represent a disproportionate share of the uninsured population. About 40 percent of preschoolers do not receive the recommended doses of lifesaving vaccines. Again, low-income and minority children stand out in the group. Thousands of families with children who have special health care needs struggle to make ends meet while facing enormous health care costs and discrimination in the insurance marketplace. Adolescents, especially those in low-income families who have not yet benefited from Medicaid eligibility expansions, face unique health care issues. Risky behaviors compound the access issues faced by their younger counterparts.

Recent emphasis on children's health prompts legislators to examine their own state's child health status indicators and policies and programs to improve them. The U.S. Department of Health and Human Services promotes national health objectives related to mothers, infants, children, adolescents, and youth. *Healthy Children 2000*, published in 1991, lists approximately 170 objectives to improve the health status of the nation's children.¹

Healthy Children 2000 objectives cover a range of issues including clinical preventive services, immunization and infectious diseases, maternal and infant health, nutrition, physical activity and fitness, and a variety of other health problems and risky behaviors. Using their own data, states can monitor their progress toward achieving the objectives. In addition, recent federal expansions in Medicaid both require and enable states to expand their Medicaid programs to serve more low-income children.

States lead the country in health care reform initiatives, many of which address access needs of the millions of uninsured children. This publication highlights a variety of state efforts to improve health care services and availability to children and youth.

*NCSL's companion publication, *Healthy Babies: State Initiatives for Pregnant Women At Risk*, highlights state programs to provide prenatal care to high-risk women. Copies may be obtained from NCSL's Denver office.

Insurance

BACKGROUND

About 9.5 million children, or 14.7 percent of Americans under age 18, lack health insurance.² Approximately 11.4 percent of white children lack insurance, compared with 28.5 percent of Hispanic children, 18.2 percent of African American children, and 16.2 percent of children in other race categories.³ Rates for uninsured persons vary widely among states, ranging from a low of less than 10 percent to a high of approximately 25 percent (see table 2).⁴ Much of the variation relates to two factors: differences in Medicaid eligibility levels among states (see table 2); and availability of employment-based insurance coverage, which is affected by the types and sizes of businesses and by local unemployment rates.

About 57 percent of uninsured children live with a parent employed full time all year. Another 23.6 percent live with a parent who works either part time or full time part of the year.⁵ Employment-based insurance for dependent children dropped 13.6 percent between 1977 and 1987.⁶ For families with incomes between 100 percent and 200 percent of the federal poverty level, the decline was almost 26 percent; by 1987, only 47 percent of children living in such families had employment-based insurance.⁷ See table 1 for the 1993 federal poverty guidelines.

Even when family coverage is offered, premium costs for dependents often exceed the ability of workers to pay for them. About 75 percent of uninsured children live with workers who earn less than twice the federal poverty level.⁸ Of workers with family coverage in 1989, 64 percent paid partial costs for premiums, averaging \$71.41 per month.⁹

Even insured children may lack access to certain health services not covered by their insurance plans. Only 39 percent of conventional insurance plans covered well-child care services in 1990, and only 47 percent covered immunizations.¹⁰ A full series of childhood immunizations costs more than \$230 per child just for the provider to purchase the recommended doses.¹¹ When office visit charges are added to immunization costs for a normal well-child visit, out-of-pocket expenses may be prohibitive for both uninsured and insured families. The term "underinsured" applies to persons with some health insurance, but for whom out-of-pocket expenses for copayments, deductibles, or uncovered services may be more than they can pay.

More poor children lack health insurance coverage than those in middle- and upper-income families. About 70 percent of uninsured children live in families with incomes below twice the federal poverty level, or approximately \$23,780 for a family of three.¹² About one in five of children in families with income below the FPL lack health insurance, including private coverage or Medicaid: 30.6 percent of poor Hispanic children; 16.4 percent of poor African American children; 19.8 percent of poor children in other minority groups; and 23.5 percent of poor white children.¹³

Compared with their insured counterparts, uninsured children lack a regular source of health care. For example, 17.6 percent of infants with family income below \$10,000 had no regular source of care in 1988, compared with 5.6 percent of infants with family income above \$40,000.

Comparing the same income groups for teens ages 15 to 17, one-quarter of low-income teens lacked a regular source, compared with 13 percent of the upper income group.¹⁴

TABLE 1: 1993 FEDERAL POVERTY GUIDELINES

Size Family Unit	Poverty Guidelines (U.S.)	Poverty Guidelines (ALASKA)	Poverty Guidelines (HAWAII)
1	\$6,970	\$8,700	\$8,040
2	\$9,430	\$11,780	\$10,880
3	\$11,890	\$14,860	\$13,680
4	\$14,350	\$17,940	\$16,500
5	\$16,810	\$21,020	\$19,320
6	\$19,270	\$24,100	\$22,140
7	\$21,730	\$27,180	\$24,960
8	\$24,190	\$30,260	\$27,780

Source: U.S. Department of Health and Human Services.

TABLE 2:
UNINSURED POPULATION DATA AND MEDICAID ELIGIBILITY THRESHOLDS BY STATE

States	Nonelderly Population without Health Insurance ^a 1991 Average	Medicaid Eligibility Threshold Family of 3 ^b January, 1993	Medically Needy Percent of Poverty ^c	Expansions for Infants and Pregnant Women ^c
Alabama	20.6%	16.6%	—%	133%
Alaska	15.7	76.7	—	133
Arizona	21.1	35.0	—	140
Arkansas	18.5	20.6	27.8	133
California	21.7	63.0	94.3	185
Colorado	11.8	42.5	—	133
Connecticut	8.8	58.6	78.0	185
Delaware	15.8	34.1	—	185
District of Columbia	30.3	41.3	55.0	185
Florida	23.5	30.6	30.6	185
Georgia	16.9	42.8	37.8	150
Hawaii	9.0	60.8	60.8	185
Idaho	20.6	55.9	—	133
Illinois	13.5	37.0	49.7	133
Indiana	15.0	25.8	—	150
Iowa	10.5	43.0	57.1	185
Kansas	13.7	43.3	48.4	150
Kentucky	15.9	53.1	31.1	185
Louisiana	23.8	19.2	26.0	133
Maine	13.1	55.8	46.2	185
Maryland	15.5	36.2	42.1	185
Massachusetts	13.2	58.4	78.2	185
Michigan	10.5	55.6	57.2	185
Minnesota	11.2	53.7	71.6	185
Mississippi	22.1	37.1	—	185
Missouri	14.0	29.5	—	133
Montana	14.7	50.2	44.7	133
Nebraska	10.2	36.7	49.7	133
Nevada	21.8	35.1	—	133
New Hampshire	11.5	52.1	62.2	150
New Jersey	12.7	44.7	59.6	185
New Mexico	24.5	32.7	—	185
New York	14.7	58.2	77.4	185
North Carolina	17.8	54.9	37.0	185
North Dakota	9.2	40.5	43.9	133
Ohio	12.2	34.4	—	133
Oklahoma	22.1	47.5	46.3	150
Oregon	16.8	46.4	61.9	133
Pennsylvania	9.4	42.5	47.1	185
Rhode Island	12.3	55.9	74.8	185
South Carolina	15.5	44.4	—	185
South Dakota	12.6	40.8	—	133
Tennessee	16.0	43.0	25.2	185
Texas	25.3	18.6	26.9	185
Utah	15.8	54.2	54.1	133
Vermont	14.8	66.5	89.1	200*
Virginia	19.6	29.4	36.1	133
Washington	12.4	55.1	67.3	185
West Virginia	18.5	25.1	31.5	150
Wisconsin	9.6	52.3	69.5	155
Wyoming	13.8	36.3	—	133

^a Source: Employee Benefit Research Institute (see note # 2).

^b Based on eligibility for AFDC as a percentage of the federal poverty level. Source: National Governors' Association.

^c Source: National Governors' Association.

* See information about Vermont's further expansion in the "Medicaid" section.

In *Healthy Children 2000*, the U.S. Department of Health and Human Services calls for at least 95 percent of Americans to have a specific source of ongoing primary care for coordination of their preventive and episodic health care. In addition, financing and delivery of clinical preventive services should be improved so that virtually no American has a financial barrier to receiving, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force.¹⁵

STATE APPROACHES

A number of states sponsor initiatives to insure more children. A *Florida* pilot program provides health insurance coverage through the public schools. *Minnesota* and a few other states sponsor state-level group plans or subsidize private sector insurance for low-income children. *Iowa's* Caring Program for Children provides insurance coverage through a public-private partnership. Several states require health insurance plans to cover well-child care and a few require health coverage for children in divorce cases. The "Medicaid" section describes state efforts to enroll more uninsured children in state Medicaid programs.

SCHOOL ENROLLMENT-BASED GROUP HEALTH INSURANCE

Program Highlight. The Florida Healthy Kids Corporation provides comprehensive health insurance to uninsured school children and youth on a pilot basis. Participating school districts verify eligibility for their "group" of qualified children.

Legislation. The Florida Legislature created the Healthy Kids Corporation in 1990 to phase in comprehensive health insurance coverage for the state's 500,000 uninsured school children and to facilitate preventive health care services to those children. The original act authorized four pilot sites, expanded to 10 in 1991. The corporation determines eligibility and premium amounts, contracts with health care providers, publicizes the program, contracts with school boards, and hires administrative staff (Fla. Stat. sec. 624.91).

Eligibility. To enroll in the Healthy Kids plan, children and youth must meet the following criteria: be between ages five and 19, attend a participating school, and not participate in other public assistance. Dependents and younger siblings, ages three

through five, of eligible school children may also participate in the program. No income restrictions apply, although families pay a fee based on income. The plan may not exclude children with pre-existing health conditions, and children may receive services immediately upon enrollment.

Administration. Representatives from the following groups comprise the Healthy Kids Corporation board of directors: Association of School Administrators, Association of School Boards, Department of Education, Pediatric Society, Children's Medical Services Program, Hospital Association, health insurers, Institute for Child Health Policy, family physicians, and the state health officer (or a designee). The insurance commissioner (or designee) chairs the board.

In Volusia County, the first pilot site, a local steering committee advises the board and helps shape the project's design. The committee provides community outreach, educates parents about getting medical care for their children, and assists families who have difficulty making premium payments. School district cooperation is essential for identifying potential participants, publicizing the program through mailing lists and school-based meetings, and providing data about family income and birth dates for wellness check reminders.

Implementation. Volusia County (the Daytona Beach area), chosen for the initial pilot project, has about 50,000 students, a substantial number of whom lack insurance. The following three phases exist:

- 1) Coverage of eligible school-aged children and youth, which began February 1, 1992;
- 2) Coverage of preschool siblings ages three through five and dependents of school children, which began October 1, 1992; and
- 3) Coverage of the parents of eligible children, which may occur in the future.

Florida Health Care Plan, Inc., a local health maintenance organization (HMO), provides the physician network and health services for Healthy Kids in Volusia County. Families choose their own primary care physicians, backed up by participating specialists.

In January 1993, the board approved expansion of Healthy Kids to six more counties, subject to legislative approval and funding. The two most likely counties for expansion in the near future are

Hillsborough, an urban area that includes Tampa, and Highlands, a largely rural county in the south central part of the state.

Services. The insurance plan covers well-child care visits and immunizations, primary and specialty physician office visits, inpatient hospital care, surgical procedures, emergency services and transportation, prescriptions, vision screening and glasses, hearing screening and hearing aids, physical therapy, and mental health services.

Funding. Impetus for Healthy Kids came from the Institute for Child Health Policy, which obtained grants from the federal Maternal and Child Health Bureau and The Robert Wood Johnson Foundation. The legislature appropriated \$83,500 in the first year for start-up costs and has appropriated \$3.2 million in additional funds to date. The legislature also created the Florida Healthy Kids Trust Fund to receive contributions, appropriations, grants, and premiums. The federal Health Care Financing Administration (HCFA) funded a \$7 million four-year grant to help with development and administration of the program. A combination of state and federal money subsidizes premiums. Private contributions by local businesses toward printing and marketing help keep administrative costs low.

Participating families pay a monthly premium for each child, based on family income, as follows: nothing for families with income up to the federal poverty level; \$3 for those with income from 101 to 135 percent of the FPL; \$16 for those with income between 135 and 186 percent of the FPL; and \$57, or full cost, for those with higher income. Using family income reported by schools for the National School Lunch Program eliminates the need to collect separate income data to determine premium payments. Participants pay a small charge for emergency services, prescription drugs, and mental health services, but no charge for doctor office visits and hospital stays.

Evaluation. As of December 1992, about 8,000 children had enrolled in the Healthy Kids Volusia County pilot project. Program administrators report that both insurance premium costs and service usage are slightly lower than initial projections. As a result, a 5 percent reduction in premiums became effective in November 1992. The full cost of a monthly premium dropped from \$60 to \$57 per participant. The Institute for Child Health Policy monitors the program for coverage of uninsured children, administrative expenses, and market penetration for coverage of eligible children.

According to the institute, the Volusia County pilot project has enrolled 63 percent of the children estimated to qualify for a full subsidy. In a random telephone survey of enrolled families, only 4 percent reported no source of regular medical care. HCFA has contracted for a program evaluation that compares the pilot project with a control county.

Program Limitations or Concerns. Implementation of the first pilot program has been smooth, without major surprises or roadblocks. As in most states, concern exists about the Florida economy, state budget problems, and whether the state can continue providing money to fund the program or expand it to more counties.

Contact: Florida Healthy Kids Corporation, 345 S. Magnolia Drive, Suite E-17, Tallahassee, Florida 32301; (904) 878-8566.

Similar Initiatives. Kansas passed legislation in 1992 to establish the Kansas Healthy Kids Corporation. The Kansas program, to begin in three pilot sites by July 1, 1994, will cover basic dental care in addition to preventive and primary care services. It also includes coverage for siblings who are not students (Kan. Stat. Ann. sec. 40-4401 et seq.).

STATE-SPONSORED OR SUBSIDIZED INSURANCE

Program Highlight. Minnesota's state-sponsored Children's Health Plan (CHP) covers more than 31,000 children, ages one through 17, for primary and outpatient health care services. (Note: Although implementation of the new MinnesotaCare program first expands and then absorbs the Children's Health Plan, this section highlights the CHP as an autonomous program to illustrate a state-sponsored health insurance program for uninsured children. Additional comments in the indented paragraphs indicate how the MinnesotaCare program is changing the CHP.)

Legislation. The Minnesota Legislature created the Children's Health Plan in 1987 to "promote access to appropriate primary health care to assure healthy children." The original legislation covered children ages one through eight, with subsequent expansion to age 18 (Minn. Stat. Ann. sec. 256.9351).

Minnesota's HealthRight legislation (now called MinnesotaCare), adopted in 1992, contains numerous health care reform initiatives. The portion that expands the

Children's Health Plan into the more comprehensive MinnesotaCare plan amended sec. 256.9351.

Eligibility. Under the original Children's Health Plan, eligible children have family incomes up to 185 percent of the FPL, do not qualify for Medicaid or general assistance medical care, and lack insurance for services covered under the CHP. Under the new MinnesotaCare legislation, children with family income up to 275 percent of the federal poverty guidelines became eligible for the CHP effective January 1, 1993. This level allows coverage for a family of three with income up to \$32,640. The Children's Health Plan will accept enrollments until July 1, 1993, and phase out as MinnesotaCare phases in.

Parents and siblings of CHP-eligible children may enroll in MinnesotaCare if they are permanent Minnesota residents, do not qualify for medical assistance, and lack access to employer-subsidized coverage for at least 18 months. If an employee qualifies for employer-subsidized coverage, but his or her dependents do not, the dependents may qualify for the MinnesotaCare plan. As of January 1, 1993, additional families with income up to 275 percent of the FPL may purchase coverage in MinnesotaCare on an income-based sliding scale if they have children, have been uninsured for at least four months, and meet the other qualifications listed at the beginning of this paragraph. Finally, beginning July 1, 1994, any permanent Minnesota resident with income up to 275 percent of poverty who meets the criteria listed for families may enroll and pay premiums on a sliding scale basis.

Administration. As a state-run insurance program, the Children's Health Plan has close ties to the state's Medicaid program. The commissioner of human services oversees the CHP, markets it, and determines eligibility. The program distributes information and application forms to health care provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced-price lunches, community health offices, and WIC program sites (the federal Special Supplemental Food Program for Women, Infants, and Children). To participate in the Children's Health Plan, service providers must also serve Medicaid patients. The CHP pays providers the same rates as Medicaid, using existing invoice forms and procedures. The commissioner of human services continues administrative responsibilities for

the expanded CHP, including new duties related to eligibility and premium payments.

Implementation. Begun in July 1988, the Children's Health Plan first covered children through age eight and served approximately 11,000 children in its first year. After expansion in 1991 to cover children and youth up to age 18, the plan currently serves about 31,300 children and youth. As the state expands Medicaid eligibility, CHP-covered children who become eligible for Medicaid are shifted to Medicaid in order to maximize federal funds for medical services.

As described in previous sections, the Children's Health Plan phases out by July 1, 1993, when participating children shift to the MinnesotaCare plan.

Services. The Children's Health Plan emphasizes preventive and primary care. Benefits cover clinic and doctor visits, hospital outpatient services, dental care (except orthodontics), outpatient mental health services (up to \$2,500 annually), vision care and prescription eyeglasses, and prescription drugs. The CHP excludes inpatient care and most of the more intensive services needed by children with special health care needs. In response to concern about children with special health care needs, the state's Services for Children with Handicaps Program combined with the CHP in November 1989 to address both well-child care and acute care needs for eligible children. Program planners hoped to cover acute care services and hospital care for the general CHP population, but such coverage proved too expensive.

New funding sources under the MinnesotaCare plan allow for expanded services. Coverage for limited treatment for alcohol and drug dependency began October 1, 1992. Coverage for inpatient hospital services and emergency medical transportation services commences July 1, 1993, for eligible MinnesotaCare participants.

Funding. First funded in 1988 with proceeds from a one-cent hike in the state's cigarette tax, the Children's Health Plan received \$12.5 million for FY 93 from the state's general fund. In addition, families pay \$25 per child annually, up to \$150 per family. Annual program costs in FY 1991 totaled \$184 per child, of which \$154 paid for health care services and \$30 paid for administrative costs. As "payer of last resort," the CHP bills other public or private insurance plans for services or persons covered by them. To capture federal matching

funds, the program screens children for Medicaid eligibility and enrolls eligible children in Medicaid rather than in the CHP. Those enrolled in the CHP who become eligible for Medicaid are shifted to that program.

The new MinnesotaCare legislation created a Health Care Access Fund, with revenues from several sources: a five-cent increase in the cigarette tax to 48 cents per pack; a 2 percent tax on gross patient hospital revenues, which began January 1, 1993; a 2 percent tax on the gross revenues of other health care providers, starting January 1, 1994; and a 1 percent premium tax on nonprofit health services corporations, including health maintenance organizations and Blue Cross and Blue Shield (BC/BS) of Minnesota, beginning January 1, 1996. The MinnesotaCare program received \$13.3 million for FY 93. Enrolled families pay premiums based on size and gross family income, ranging from \$2 to \$235 per month, which is the full estimated cost of the premium for a family of two or more people. Premiums will increase after inpatient services begin on July 1, 1993. In addition, adult enrollees will make copayments for inpatient care, dental services, prescriptions, and eyeglasses.

Evaluation. More than 96,000 children have received care under the Children's Health Plan over the past five years. From 1989 to 1990, the number of CHP-covered children who used well-child care increased from 63 percent to 68 percent. During the same period, well-child care visits under Medicaid remained steady at 56 percent.

The most frequent services received under the CHP include physician, dental, prescription medications, and outpatient hospital services. Treatments for respiratory illnesses, vision care and eyeglasses, accidents, and infections account for the greatest expenditures across all ages. Expenditures for the CHP exceeded budget projections in the past year due to higher than projected enrollment and a higher cost than anticipated for older children added to the CHP.

Program Limitations or Concerns. The costs of providing inpatient hospital services under the CHP proved prohibitive without additional funding. Children enrolled in the CHP who required hospital care often could be transferred to Medicaid by meeting that program's spend-down requirements.

Contact: Children's Health Plan or MinnesotaCare, 444 Lafayette Road North, St. Paul, Minnesota 55155-3829; (612) 297-3862.

Similar Initiatives. A number of other states sponsor initiatives to insure more children. Although not an exhaustive list, the following examples provide a brief summary of a variety of different approaches to a common goal.

New York. The New York Legislature created a child health insurance plan in 1990, dubbed "Child Health Plus." In contrast to the Minnesota Children's Health Plan, which created a new state program tied closely to Medicaid, Child Health Plus subsidizes private sector insurance premiums for eligible children. Administered by the Department of Health, the plan covers children through age 12 in families with income below 220 percent of the FPL. Higher income families may purchase unsubsidized coverage for uninsured or underinsured children.

The state contracts with local insurers or health plans to market, underwrite, and provide primary and preventive health services to participants. Outreach efforts target employment sites, school districts, parent organizations, unemployment and income maintenance centers, homeless shelters, day care centers, churches, community newspapers, government relief programs, hospitals, and ambulatory care network sites. In addition to participant premiums, funding comes from New York's bad debt and charity care pool, totalling approximately \$62 million for 1991-93. In its first year, the plan enrolled 36,000 children (N.Y. Public Health Law sec. 2510 et seq.). Contact: Child Health Plus, Bureau of Community Health Insurance and Finance Systems, Empire State Plaza, Tower Building, Room 1168, Albany, New York 12237; (518) 474-5050.

Pennsylvania. The Pennsylvania Child Health Care Act, adopted in December 1992, provides state-subsidized insurance for low-income children. Uninsured children under age six with family income up to 185 percent of the FPL receive free coverage. Children ages six to 12 with family income up to the FPL also qualify for free insurance. The plan, beginning in April 1993, phases in older children year by year to cover through age 17 by 1996. As children qualify for Medicaid under the federal requirements for Medicaid expansions, Pennsylvania shifts state-subsidized children to the Medicaid program.

The Pennsylvania plan also subsidizes coverage for other families with children under age six. Those with incomes between 185 and 235 percent of the FPL may purchase coverage at half price, estimated at \$450 per child annually, or \$37.50 per month.

The insurance plan covers preventive care, including immunizations; diagnosis and treatment of illness or injury; emergency accident and emergency medical care; inpatient hospitalization up to 90 days per year; prescription drugs with a \$5 copayment; and emergency, preventive, and routine dental, hearing, and vision care. Children with pre-existing conditions may not be denied coverage, nor may diagnosis or treatment be excluded based on a condition's pre-existence.

Pennsylvania funds its insurance program with a two-cent-per-pack increase in the state's cigarette tax, bringing in an estimated \$21.5 million per year. The Department of Insurance contracts with U.S. Healthcare, an HMO, and with Pennsylvania Blue Shield and the state's four regional Blue Cross Plans to administer the program. A variety of providers may apply to participate, including clinics, group and individual practices, managed care providers, and hospital outpatient departments (1992 Pa. Laws, Act 113). Contact: Insurance Department, Program Services, 1326 Strawberry Square, Harrisburg, Pennsylvania 17120; (717) 787-4298.

Connecticut. In 1990, the Connecticut General Assembly authorized a state subsidy to purchase health insurance for low-income uninsured children. Planned and advertised in 1992 as a pilot demonstration project called "Healthy Steps," the program will enroll up to 1,000 eligible children from the New Haven school system, from January 1, 1993, through December 31, 1993. To apply, participants must be uninsured, ineligible for Medicaid, under age 14, and have family income below 200 percent of the FPL. The program originally targeted school-aged children, then expanded to include preschoolers enrolled in Head Start. New Haven's public and private schools sent program information memos, attractive brochures, and application forms home with school children. The local health department, which conducts outreach and screening efforts, refers applicants who appear to meet Medicaid eligibility criteria to the Medicaid program. As of January 1993, 200 applicants had been referred.

The state contracts with Blue Cross and Blue Shield of Connecticut, Inc., to provide a range of health care services, including primary and preventive care; diagnostic services; prescription drugs; therapies such as radiation, chemotherapy, kidney dialysis, and physical, occupational, and speech therapy; outpatient mental health; basic dental care; and inpatient hospital care. BC/BS actively markets the program through outreach activities and conducts eligibility determinations. The Healthy Steps program provides services through the BC/BS preferred provider organization, a managed care network. Participating clinics and hospitals submit claims directly to BC/BS, so enrollees pay no out-of-pocket costs for direct services. The program emphasizes self-care education, and participants receive a publication called *Taking Care of Your Child*, printed in either English or Spanish.

Participating families pay \$5 per month per child, or a maximum of \$240 annually per family. Although the program drops families that fail to pay, program staff conduct vigorous outreach to prevent such action. The state subsidizes the insurance premiums with a \$1 million appropriation from the state's uncompensated care pool. Premiums cost \$1,000 for each child for the trial year. The legislature also appropriated \$315,000 in general funds for administrative costs and an evaluation (Conn. Gen. Stat. sec. 19a-7c). Contact: Health Care Access Commission, Room 3000, Legislative Office Building, Hartford, Connecticut 06106; (203) 240-0563.

Hawaii. Hawaii's State Health Insurance Program (SHIP), created in 1989, subsidizes private insurance coverage for medically uninsured residents with incomes up to 300 percent of the FPL. Persons with family income under the FPL receive a full subsidy and others participate on a sliding-fee scale, based on family size and income. Because Hawaii law requires employers to provide insurance coverage to most workers, the SHIP program targets unemployed, self-employed, and part-time workers; the children and spouses of low-income workers; and students. About 43 percent of SHIP enrollees in 1991 were under age 19. Covered benefits emphasize preventive care and include perinatal care, well-child care, immunizations, health appraisals and related tests, up to 12 physician visits per year, and limited hospitalization (Hawaii Rev. Stat. sec.

431N). Contact: Hawaii Department of Health, State Health Insurance Program, 1000 Bishop Street, Room 312, Honolulu, Hawaii 96813; (808) 586-4141.

Massachusetts. The legislature created the Health Care Access Fund in 1991 and required the Department of Medical Security to establish a program of preventive pediatric health care services for the benefit of dependent and adoptive children, from birth through age six. Called "Healthy Kids," the new Massachusetts program subsidizes insurance coverage for uninsured children. To administer the program, the department contracts with two insurers: the Community Health Plan, at a premium cost of \$42.46 per month per child; and Blue Cross and Blue Shield of Massachusetts, Inc., at a premium cost of \$40.71 per month per child. The state pays the full cost of premiums for children in families with income through 200 percent of the FPL; those with income from 134 through 200 percent of the FPL pay small copayment and deductible charges. Families with income between 200 and 400 percent of the FPL pay copayments, deductibles, and the first 40 percent of premium costs. Participating families with income above 400 percent of the FPL pay the full cost of premiums, copayments, and deductibles. The legislature appropriated \$5 million for the program in FY 1993, with revenues from cigarette taxes and from federal financial participation funds under Medicaid for disproportionate share hospitals.

Healthy Kids emphasizes primary and preventive care. The program covers immunizations; screening for a variety of conditions, including lead poisoning; and periodic assessments, including at least six during the child's first year, three during the second year, and at least one each year through age five. The program does not cover inpatient hospitalization, emergency room treatment, mental health services, dental care, and other services required for more intensive health care needs (Mass. Gen. Laws Ann. ch. 118F, sec. 17A, as appearing in sec. 23 of ch. 495 of the Acts of 1991). Contact: Healthy Kids Program, Department of Medical Security, One Ashburton Place, Room 1105, Boston, Massachusetts 02108; (617) 727-8300.

Vermont. Vermont's Dr. Dynasaur Program began in 1989 as a state-funded health insurance program for uninsured children up to age six in families with income up to 225

percent of the FPL and for pregnant women with family income up to 200 percent of the FPL. The program expanded in 1992 and converted all enrollees to Medicaid, as described in the "Medicaid" section.

PUBLIC-PRIVATE INSURANCE PARTNERSHIP

Program Highlight. Iowa's Caring Program for Children, a joint public-private insurance program, covers primary and preventive health care for eligible children. Blue Cross and Blue Shield of Iowa initiated the program in 1989 based on the original Caring Program for Children in western Pennsylvania. Support from the state legislature makes the Iowa program somewhat unique among other Caring Program for Children initiatives.

Legislation. The Iowa General Assembly earmarked \$1.3 million in 1989 to support the Caring Program for Children over a three-year period. In response to later state budget problems, the legislature reduced its contribution to a total of \$500,000.

Eligibility. The Caring Program for Children covers children through age 18 in families with incomes up to 133 percent of the FPL, if they are not eligible for Medicaid or other government programs. An estimated 25,000 Iowa children meet the eligibility requirements. In January 1993, 2,500 children were participating in the program, with 400 on the waiting list.

Administration. Blue Cross and Blue Shield of Iowa administers the program, determines eligibility, and processes claims. A board of directors and an advisory cabinet oversee the program. Participating children receive Caring Program identification cards with the BC/BS logo and receive services in the same way as other BC/BS subscribers.

Implementation. Iowa's Caring Program for Children began in December 1989 with 100 children and plans to cover 3,000 within three years. By the end of 1992, the plan had served 5,000 children. As enrolled children's families gain more income or children qualify for Medicaid, they move out of the program.

Services. The Caring Program for Children's basic benefits cover primary and preventive services, including a full range of outpatient services, office visits, immunizations, physical exams, diagnostic tests, emergency medical care, and minor surgery. Beginning in February 1993, two county pilot sites

cover dental services, emphasizing preventive care, primary restoration, and good oral hygiene. The plan does not cover inpatient care, although three hospitals provide care to program participants free of charge.

Funding. The general assembly requires a match for its state appropriations, as follows: \$2 for every state dollar in the first year; \$3 in the second year; and \$4 in the third year. BC/BS of Iowa donated \$3 million over six years to support the plan. BC/BS established the Caring Foundation to receive tax-deductible contributions. Donations come from private contributors, including health care providers, community groups, religious organizations, businesses, foundations, and individuals. The benefit package costs \$25 per child per month, or \$300 annually. Enrolled families pay no out-of-pocket costs. Participating physicians and hospitals provide substantial discounts, which helps keep program costs low.

Evaluation. The program serves approximately 20 percent of the potential market of uninsured children. An advisory cabinet with members from business, labor, and the social and civic communities helps evaluate the program's impact on meeting the needs of enrollees and potential enrollees. The advisory cabinet has collected many comments of appreciation from parents of enrolled children.

Program Limitations or Concerns. The program covers as many children as funding allows, which represents an estimated 20 percent of those eligible. Program administrators undertake fund raising to make up for the cutback in the original earmarked state appropriations. Relying on charity funding sources makes the program vulnerable to cuts and impedes its ability to expand as desired. Also, program services do not cover inpatient care.

Contact: Caring Program for Children, Blue Cross and Blue Shield of Iowa, 636 Grand Avenue, Des Moines, Iowa 50309; (515) 245-4500.

Similar Initiatives. In 1985, Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield pioneered the Caring Program for Children, which serves as a model for Iowa and other states. A group of ministers approached Blue Cross of Western Pennsylvania in 1984 to help address the needs of 40,000 low-income uninsured children in the area. Since then, the program has served more than 17,000 children.

Through a grant from the federal Maternal and Child Health Bureau, Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield facilitate replication of the Caring Program in other states. As of January 1993, 20 programs operate in 18 states, including *Alabama, California, Iowa, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Texas, Utah, and Wyoming*. Legislatures in *Iowa, Kansas, and Michigan* appropriate state funds to help with their programs.

Contact: Caring Program for Children, 500 Wood Street, Suite 600, Pittsburgh, Pennsylvania 15222; (412) 645-6202.

INSURANCE MANDATES FOR WELL-CHILD CARE

As mentioned in the "Background" section, only 39 percent of conventional insurance plans covered well-child care services in 1990. In contrast, most health maintenance organizations cover well-child care services and immunizations. At least 11 states require insurance plans that provide family coverage to pay for well-child services for certain children. It should be noted that the federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured companies, except in Hawaii, which has an exemption under the federal law. The federal provision excludes self-insured companies from the insurance mandates described here. Between 1974 and 1990, the number of employees covered by self-insured ERISA plans nationwide jumped from 5 percent to 56 percent.¹⁶

In 1986, *Florida* led the nation in requiring family insurance plans to cover child health supervision services. Children from birth through age 16 must be covered for up to 18 visits, based on the schedule recommended by the American Academy of Pediatrics (AAP). Covered services include a medical history, physical exam, appropriate immunizations and laboratory tests, developmental assessment, and anticipatory guidance (which means providing information about what to expect next in normal childhood development). Coverage is exempt from any deductible provisions (Fla. Stat. sec. 627.6416).

At least 10 other states and the District of Columbia require coverage for well-child services by insurance policies that include dependent children. Unless otherwise specified, covered services include those listed under the preceding Florida description.

California requires health care service plans issued after December 31, 1992, to cover comprehensive preventive care for children through age 16, including lead poison screening. Coverage for the benefits must be offered for youth ages 17 and 18, and screening for lead poisoning must be covered (Cal. Health and Safety Code secs. 1367.3 and 1367.5 and Cal. Insurance Code secs. 10123.5 et seq. and 11512.17 et seq.).

Connecticut requires coverage for up to 13 well-child visits for children from birth through age six (Conn. Gen. Stat. Ann. sec. 38a-535).

The **District of Columbia** requires coverage for unlimited visits for children under age 12, and three visits per year for children ages 12 to 18. In addition to primary and preventive care services, plans also must cover injury or sickness, including the "necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity" (D.C. Code Ann. sec. 35-1102 et seq.).

Hawaii covers children from birth through age five, with up to 12 visits (Hawaii Rev. Stat. sec. 431:10A).

Iowa legislation adopted in 1992 authorizes the commissioner of insurance to require insurance coverage for routine well-baby care for infants from birth to age two (Iowa Code Ann. sec. 514H.7A).

Maryland, which does not specify an age limit, requires insurance policies to cover visits for immunizations; screening for PKU (phenylketonuria, a treatable metabolic disorder that can cause mental retardation), tuberculosis, anemia, lead toxicity, hearing, and vision according to the AAP schedule; physical exams; developmental assessment; and anticipatory guidance (Md. Ann. Code art. 48A, secs. 354KK, 470AA, and 477KK).

Massachusetts requires coverage for children from birth to age six for up to 13 visits based on the AAP schedule (Mass. Gen. Laws Ann. ch. 176A, sec. 8B).

Minnesota requires coverage for children from birth through age five for up to 13 visits according to the AAP schedule. The law prohibits deductibles and copayments for covered services (Minn. Stat. sec. 62A.047).

Montana requires coverage for children from birth through age two. The law specifies that periodic services should be provided according to the schedule of visits adopted under the Medicaid Early and Periodic, Screening, Diagnostic, and Treatment Program. Coverage also includes routine immunizations, as recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services. Benefits must be exempt from deductible payments (Mont. Code Ann. secs. 33-22-303; 33-22-512; and 33-30-1014).

Ohio requires insurance policies issued after June 30, 1993 to cover child health supervision services from birth to age nine. Cost of the mandated benefits may not exceed \$500 for infants to age one, or \$150 per year for older children. Policies may limit benefits to cover only the expenses of services performed by one physician or someone supervised by one physician during the course of any one visit. Any copayments and deductibles must not be a barrier to the necessary utilization of covered services (Ohio Rev. Code Ann. sec. 3923.55 et seq.).

Rhode Island covers children from birth through age 19 for "pediatric preventive care," defined as services recommended by the AAP. No mandate exists for the cost of vaccine because Rhode Island purchases and distributes vaccine to make it accessible to all children, as described in the "Immunization" section. The law prohibits deductibles, but allows copayments up to the amount charged for other physician office visits, as long as they do not "pose a barrier to obtaining pediatric preventive care" (R.I. Gen. Laws sec. 27-38.1-1 et seq.).

INSURANCE IN DIVORCE SETTLEMENTS

In considering health insurance coverage for children in divorce cases, state policymakers concern themselves with two different populations: children who qualify for Medicaid through the Aid to Families with Dependent Children (AFDC) program, and those who lack health insurance but do not qualify for AFDC.

AFDC-Eligible Children. In the case of AFDC-eligible children, who automatically qualify for Medicaid, federal law requires states to "take steps to ensure" that noncustodial parents provide health insurance if it is available through their employer.

As payer of last resort, Medicaid then pays for only those services not covered under the private insurance plan. A recent General Accounting Office (GAO) report indicates that the majority of states do not adequately comply with the requirement and that at least \$122 million in Medicaid costs could be saved annually if states enforce it.¹⁷

According to the GAO report, the federal law lacks specificity, and states are hampered by their lack of ability under ERISA to regulate self-insured companies, as discussed earlier. Although a review of state practices concerning child support enforcement provisions and health insurance is beyond the scope of this publication, the GAO studied 12 states to determine whether they have done the following:

- Established a monitoring system to identify noncomplying noncustodial parents;
- Adopted legislation to require employers to provide insurance information to the state;
- Adopted legislation to allow enforcement through the employer, such as deducting wages to pay premium costs;
- Adopted time frames for enforcing orders;
- Adopted procedures and time frames for transferring health information to Medicaid; and
- Implemented management reports that track medical support cases for follow-up.¹⁸

Of the 12 states studied (*Arkansas, California, Connecticut, Maryland, Michigan, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah,*

and Washington), only Arkansas and Washington reported all of the enforcement controls listed here, although Utah was close. Using caseworkers to identify and follow up with noncomplying noncustodial parents, Washington saved an estimated \$3.7 million in Medicaid costs during 1990.¹⁹

Other Child Support Cases. Even in divorce cases where affected children may not be eligible for AFDC or Medicaid, a few states require courts to order medical care coverage in child support cases, including *West Virginia, Minnesota, and Colorado*.

West Virginia requires courts to ascertain the ability of each parent to provide medical care for the children as part of every action to establish or modify child support payments. The court must order parents to do one or more of the following: purchase available group health insurance, obtain other health insurance coverage, or pay for reasonable and necessary medical services. If a parent with group coverage fails to comply, the law provides remedy by ordering notification of the employer, who must enroll the child in the employment-based plan, if available, and deduct the premium payment from the parent's wages. West Virginia also requires employers who provide health coverage for employee dependents to provide it without regard to legal custody, child support payments, or whether the child resides with the employee (W. Va. Code secs. 33-16-11 and 48-2-15a).

Minnesota and Colorado laws contain similar health insurance coverage provisions in divorce cases (Minn. Stat. Ann. sec. 518.171 et seq. and Colo. Rev. Stat. sec. 14-10-115 et seq.).

Medicaid

BACKGROUND

As the nation's number one insurer for low-income children, Medicaid covered approximately 13.5 million children and youth through age 17 in 1991²⁰, and thousands of additional youth through age 20. A federally matched, state-administered program, Medicaid traditionally covers persons eligible for other public assistance, such as AFDC and Supplemental Security Income (SSI). Several recent changes at the federal level dramatically expanded the populations eligible for Medicaid by allowing certain children and pregnant women to qualify for Medicaid without meeting the eligibility criteria of other public assistance programs. Such women and children are sometimes referred to as "Medicaid-only" populations. Current federal law provides the following:

- States *must* extend eligibility to children through age five and pregnant women with family incomes up to 133 percent of the FPL. "Medicaid-only" pregnant women receive only maternity-related care.
- States *must* extend eligibility to children born after September 30, 1983, with family income up to the FPL. As of September 1992, children ages six to those turning nine throughout the following 12-month period, qualify for eligibility under this provision. Eligibility phases in for youth through age 18 by the year 2002.
- States *must* extend Medicaid eligibility for one full year after birth to babies born to Medicaid-eligible women, as long as the mother continues to meet eligibility guidelines applicable to pregnant women and the baby lives with the mother.
- States *may* extend eligibility to infants (to age one) and pregnant women with family income up to 185 percent of the FPL, although states that provided such coverage before October 1, 1990 *must* continue it. Table 2 shows state income expansion percentages for infants and pregnant women. States *may* impose a premium for eligible recipients with income above 150 percent of the FPL.

- States *may* waive resource standards, also known as assets tests, for the special populations of children and pregnant women. For example, to qualify for AFDC, a family may not own a car worth more than \$1,500.

With a few exceptions, Medicaid eligibility income levels for children older than age nine correspond with state AFDC or Medically Needy program standards. As seen in table 2, eligibility thresholds range from a low of 16.6 percent of the FPL in Alabama to a high of 94.3 percent of the FPL in California. A few states have dramatically expanded their eligibility levels for older children, as described next under "Expanded Eligibility," and as illustrated by Vermont's initiative under "State Approaches."

Although mothers and dependent children now constitute about 75 percent of Medicaid recipients, they account for only 25 percent of the program's costs. Nearly 70 percent of Medicaid expenditures for health care services fund long-term care for persons who are elderly, blind, or have serious disabilities.²¹

Expanded Eligibility. In addition to the provisions just described, states apparently may now use more liberal criteria to determine financial eligibility for Medicaid, subject to approval by the Health Care Financing Administration. Under section 1902(r)(2) of Title XIX (the Medicaid statute), states may disregard defined amounts of income and other resources to expand eligibility to certain populations, including children and pregnant women. *Vermont*, for example, expanded Medicaid eligibility to children through age 17 with family incomes up to 225 percent of the FPL. In addition, the "Similar Initiatives" section under the Vermont program description mentions a few other states with such expansions.

EPSDT. The Early and Periodic Screening, Diagnostic, and Treatment Program, a mandatory service under state Medicaid programs, provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age 21. Medicaid's EPSDT program serves as a major tool in helping states meet the federal *Healthy Children 2000* goal that no American should have a financial barrier to receiving, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force.²² State EPSDT programs must include the following:

- Periodic screening services, including a comprehensive health and developmental history; a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests, including blood lead levels; and health education, including anticipatory guidance. Services must be provided at intervals that meet reasonable standards of medical practice established after consultation with recognized medical and dental organizations.

- Periodic vision, hearing, and dental services at intervals that meet reasonable standards of medical and dental practice.

- Interperiodic screening for physical or mental illnesses or conditions that arise, including vision, hearing, and dental problems.

- Diagnostic services when a screening examination indicates the need for further evaluation of an individual's health.

- Any necessary Medicaid-reimbursable health care to correct or ameliorate illnesses and conditions found in screenings.²³

EPSDT becomes an important source of health care services for low-income children with special health care needs, because of this requirement to cover any necessary Medicaid-reimbursable health care for illnesses and conditions found in screenings. The "Children with Special Health Care Needs" section describes more about this issue.

Barriers. Barriers exist both for persons seeking application for medical assistance and for those who already qualify. Simply expanding income criteria for Medicaid does not guarantee coverage for eligible persons. A large number of the millions of uninsured children nationwide may qualify for Medicaid, but are not enrolled. For example, an *Arkansas* study identified 58 percent of its uninsured children as potentially eligible for Medicaid, based on family income.²⁴ States may benefit from determining their numbers of uninsured children by age and income ranges, and whether they may qualify for Medicaid.

In many cases, low-income persons may not realize they qualify for Medicaid or other assistance programs. Even those covered by Medicaid may be unaware of its benefits and the recommended health screenings and services for children. Outreach and education campaigns can help correct these problems, as illustrated by the *South Carolina* EPSDT Outreach Program, described subsequently in this section.

Many other low-income persons apply for AFDC and Medicaid, but are denied coverage for a number of reasons, including noncompliance with numerous procedural requirements unrelated to income or resources. In several studies of the AFDC and Medicaid application processes, denials due to an applicant's failure to comply with procedural requirements, such as completing long and complicated paperwork and submitting various documents, accounted for 60 to 79 percent of total denials.²⁵

States can streamline their Medicaid enrollment procedures for "Medicaid-only" children and pregnant women in a variety of ways, including disregarding assets for eligibility, simplifying and shortening application forms, combining Medicaid eligibility forms with other public assistance programs such as WIC, expediting eligibility determinations, allowing mail-in applications, and stationing eligibility technicians in locations outside the welfare office, a practice called "outstationing."²⁶ Although federal law requires states to process Medicaid claims in certain hospitals and clinics that serve low-income populations, states may also process applications in WIC offices and other community agencies that serve low-income persons.

States also can streamline and better coordinate application processes and services for a number of other programs designed to promote the health and well-being of children and families. In response to a Congressional mandate, the U.S. Department of Health and Human Services, in consultation with the U.S. Department of Agriculture, developed a simple model application form for seven maternal and child assistance programs that receive federal funds. States may use the form for persons applying for services under Medicaid, WIC, the Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act), the Health Care for the Homeless grant program, the Migrant and Community Health Centers programs, and Head Start.²⁷ Although the model form was available to all states in 1992, the law does not require states to use it. As of August 1992, 13 states were using a joint eligibility form for two or more programs and another 16 states were in the process of developing one.²⁸

Joint application forms can save time, money, client frustration, and duplication of efforts by program personnel. *Minnesota* developed its Combined Application Form for food stamps, Medicaid, and the state's Cash Assistance Program before the model federal form was developed. The combined

form eliminated the need for dozens of other state and county forms.²⁹

Many state and federal programs typically respond to single health or social issues, and clients must seek services from several agencies. A number of states seek to improve their health and social service systems by coordinating services and making them more accessible to clients, a concept known as "one-stop shopping." More information on this issue may be found by contacting organizations listed in the appendix and obtaining publications listed in the annotated bibliography and the notes.³⁰

Children already enrolled in Medicaid face other access barriers, such as finding a health care provider who will serve them, getting to those services, and understanding what services should be received and when. The subsequent South Carolina example addresses some of these access issues.

STATE APPROACHES

Some states actively embrace outreach and education efforts to enroll more children and pregnant women in their Medicaid programs. These states view Medicaid enrollment as an opportunity to provide medical services to more uninsured persons. This section highlights *South Carolina's* efforts to conduct outreach for EPSDT enrollment and screenings, *Vermont's* expansion of its state-funded health insurance program and conversion to Medicaid, and *Louisiana's* program to screen and treat Medicaid-eligible children in public school settings.

OUTREACH AND EDUCATION

Program Highlight. South Carolina's EPSDT Outreach Program promotes Medicaid enrollment for eligible children and health care screenings and treatment for enrolled children.

Legislation. In response to collaborative efforts of Governor Richard Riley, members of the Health and Human Services Finance Commission, legislative leaders, and members of the medical community, the South Carolina General Assembly appropriated \$650,000 in 1985 to fund additional EPSDT caseworkers and outreach nurses.

Eligibility. South Carolina's Medicaid program extends coverage to infants and pregnant women in families with income up to 185 percent of the FPL;

to children through age five with family income up to 133 percent of the FPL; and children ages six to 10 with family income up to the poverty level. The following populations receive priority for outreach and services:

- 1) Infants and toddlers under age two;
- 2) Preschoolers from ages two to six;
- 3) Adolescents between ages 11 and 16; and
- 4) Newly enrolled or re-enrolled children, ages three to 13, for dental care.

Administration. Interagency cooperation among the following agencies is essential to the success of the EPSDT Outreach Program:

- The Health and Human Services Finance Commission (the state's Medicaid agency) determines Medicaid policy, pays the bills, provides enrollment and tracking forms for social services staff, sends forms for newly eligible children and children due for a screening to county social services offices, and audits county EPSDT programs periodically to determine effectiveness.
- The Department of Social Services (DSS) and local DSS agencies determine Medicaid eligibility, inform Medicaid-eligible clients about EPSDT services and the importance of well-child care and health screenings, and develop local outreach priorities. More than 50 EPSDT caseworkers, at least one per county, schedule screening appointments; identify participating providers; arrange for transportation, if needed; notify families when screenings are due; and identify and refer for outreach (to an EPSDT outreach nurse) children whose families decline EPSDT services, who miss appointments or follow-up treatment, or who participate in other public health programs, such as WIC, family planning, or prenatal care.
- The Department of Health and Environmental Control provides about 50 percent of all EPSDT screenings through local health departments, and, under contract with the Health and Human Services Finance Commission, public health nurses conduct outreach services through home visits.

State agency representatives meet regularly to promote communication and solve problems.

Interagency meetings also are conducted in the state's 13 health districts. In addition to cooperation and collaboration among participating agencies, the program also relies on cooperation from private health care providers. Outreach nurses contact physicians and encourage participation in Medicaid. Social services caseworkers and health agency outreach nurses work with local providers to assist them with client contact and program issues. The caseworkers and nurses encourage feedback to them when screening or treatment appointments are broken.

The South Carolina Medical Association encourages physicians to participate actively in both EPSDT and other Medicaid programs. The association suggests that providers add two additional Medicaid patients to their practice each month.

Implementation. Prior to 1985, Medicaid personnel noted the following problems: a high infant mortality rate, a small proportion of eligible infants enrolled in Medicaid, few enrolled infants and young children received the appropriate well-child visits or completed their immunization series, and more than 50 percent of Medicaid-eligible children missed scheduled health appointments in most areas of the state. The EPSDT Outreach Program began in 1985, with emphasis on newborns in families with incomes up to 50 percent of the FPL.

Public health nurses visited mothers of Medicaid-eligible newborns prior to hospital discharge to encourage participation in EPSDT and to provide guidance to new parents. The program emphasized follow-up in homes when mothers missed appointments for their infants. This allowed nurses the opportunity to determine why women did not participate in the EPSDT program and gave them a chance to assess the home environments, parenting skills, and family support systems. After such visits, nurses could better recommend appropriate well-child health services, provide health education, and refer families to other resources, if needed. The program expanded over time to cover the targeted populations listed under "Eligibility."

Services. Caseworkers in local social services departments educate Medicaid-eligible families about EPSDT and perform other services listed under "Administration." Outreach nurses from local health departments visit targeted families (parents of newborns and others referred by caseworkers and health care providers). The nurses recruit families for participation in EPSDT, educate them about the services for which they are eligible, and explain the importance of preventive health services. Outreach

nurses also evaluate the child's home environment, nutritional status, and overall health appearance.

South Carolina's covered health screenings under EPSDT conform to the schedule of 20 screenings recommended by the American Academy of Pediatrics, with nine between birth and age two. As required by federal law (the Omnibus Budget Reconciliation Act of 1989—OBRA-89), the program covers virtually any medically necessary Medicaid-reimbursable care identified in the health screenings.

Funding. South Carolina's 71.28 percent federal matching rate for health-related Medicaid services benefits the state. As with other states, the administrative services in the EPSDT Outreach Program are matched by the federal government at a 50 percent rate. In addition, South Carolina receives a 75 percent federal match for certain outreach activities performed by skilled medical personnel. It costs the state approximately \$25 per child for its outreach efforts, with an average caseload of 3,500 children for each nurse. The outreach program costs about \$1.6 million, and targets families listed under "Eligibility" and those who miss appointments.

In order to recruit and retain more private health care providers, the state increased its Medicaid reimbursement rates for health screenings to \$42 for infants and \$38 for older children. The state Department of Education recently began collaborating with the Health and Human Services Finance Commission. The joint effort matches state funds with Medicaid dollars to cover psychological testing and physical, occupational, and speech therapy for Medicaid-eligible school children.

Evaluation. Between FY 1985 and FY 1990, EPSDT screenings in South Carolina increased from 40,260 to 71,237. The increased numbers reflect both the state's effort to increase screenings and new children added under Medicaid expansions. Even with eligibility expansions in place, South Carolina exceeded its screening goals for three consecutive years. In FY 1991-92, the state accomplished 115 percent of its goal and performed 136,618 EPSDT screenings.

The number of families that declined EPSDT services decreased from 35 percent in FY 1985 to 13 percent in FY 1992. The number of providers willing to see Medicaid clients has increased over time. Prior to 1985, local health departments conducted approximately 85 percent of all EPSDT screenings. The proportion of screenings conducted by private physicians doubled between 1985 and

1992, to 45 percent. By 1992, more than 80 percent of the state's pediatricians participated in the program and local health departments currently conduct about 50 percent of the screenings.

On an annual basis, about 62,000 children and their parents receive home visits by outreach nurses. The nurses may provide health services, assist with reducing barriers that result in missed appointments, and help reschedule appointments. After home visitation, most families keep the follow-up appointments. Program personnel report that the outreach activities help ensure preventive care for children who need it.

Program Limitations or Concerns. Targeting resources to certain populations dramatically illustrates the need in other populations. For example, in 1989 South Carolina exceeded its EPSDT screening goals for children from birth to age five, but accomplished only 31 percent of its screening goal for children ages six to 20. In addition, program staff would like to enroll the 13 percent of eligible families who refuse services, recruit more private providers, and ensure that more children who need medical and other social services receive them. Program personnel report a shortage of pediatricians to recruit, which overloads those who participate. For every successful home visit, nurses fail to find two other families at home. Personnel report that convincing families to seek health care is sometimes difficult when they experience long waits in crowded clinics with overworked staff. Caseworkers perform most client tracking through handwritten records, so computerizing the program would greatly enhance its ability to reach families who need outreach and follow-up.

Contact: South Carolina Health and Human Services Finance Commission, Department of Health and Environmental Control, Division of Children's Health, 2600 Bull Street, Columbia, South Carolina 29201; (803) 734-3255.

ELIGIBILITY EXPANSION

Program Highlight. Vermont's "Dr. Dynasaur" program began as a state-funded health insurance program for young uninsured children and pregnant women not eligible for Medicaid. Vermont recently expanded the program and shifted enrollees to Medicaid.

Legislation. In 1989, Vermont's General Assembly directed the Department of Social Welfare to

provide health coverage for pregnant women and children through age six. A 1992 amendment extended coverage to children through age 17 and eliminated the existing copayment for well-child care. Because legislative direction was accomplished through the appropriations process, no statutory description of the program exists.

Eligibility. When it began, the Dr. Dynasaur program covered uninsured and underinsured children up to age seven in families with income below 225 percent of the FPL and pregnant women up to 200 percent of the FPL. Income criteria remain the same, but eligibility expanded in 1992 to cover children up to age 18. From the beginning, the Dr. Dynasaur program screened applicants for Medicaid eligibility and enrolled eligible persons in Medicaid. Even though the program has technically converted all participants to Medicaid, some children and pregnant women are still considered Dr. Dynasaur enrollees as a way to destigmatize public medical assistance.

Administration. The Department of Social Welfare administers both Dr. Dynasaur and Medicaid. Qualifying Dr. Dynasaur enrollees for Medicaid reimbursement simplifies administration. Private health care practitioners provide most of the medical services for participants and bill the state. Promotions for Dr. Dynasaur originally appeared on television commercials, and the program distributes attractive informational pamphlets (picturing a dinosaur in a lab coat with stethoscope) in schools for children to take home.

Implementation. Begun in 1989 as a state-funded health insurance program for low-income children through age six and pregnant women who did not qualify for Medicaid, Dr. Dynasaur expanded coverage in 1992 to include children through age 17. With recent flexibility changes in the federal Medicaid law under section 1902(r)(2), Vermont sought and received federal permission to expand Medicaid eligibility to the children and women enrolled in Dr. Dynasaur. Effective July 1, 1992, Dr. Dynasaur enrollees became eligible for Medicaid, and Vermont receives a federal match for the state dollars.

Services. From its inception, Dr. Dynasaur covered the same services as covered under Medicaid.

Funding. In FY 1992, the legislature appropriated \$625,000 for the Dr. Dynasaur program. The appropriation increased to \$1.35 million in FY 1993 to cover additional children ages seven through 17. By converting the program to Medicaid, Vermont

receives a federal match of 59.88 percent for its state appropriation. In the beginning, Dr. Dynasaur charged a small copayment for well-child care, from \$1 to \$3, depending on family income. The legislature eliminated the copayment, viewed as a barrier to access, in 1992.

Evaluation. No formal evaluation exists for the Dr. Dynasaur program. In October 1992, the program covered 1,777 children under age seven. Expanding the program through age 17 added coverage for 2,278 children and youth by October 1992. In the first six months after conversion to Medicaid (July-December, 1992), 33.2 percent of enrollees received services per month, at an average monthly cost of \$87.38 per person. The cost for the entire population, including those who did not receive medical services, averaged \$28.54 per person per month.

Program Limitations or Concerns. Some concern exists about persons with insurance who may drop it in favor of joining the Dr. Dynasaur program.

Contact: The Doctor Dynasaur Program, Department of Social Welfare, 103 South Main Street, Waterbury, Vermont 05671-1201; (802) 241-2880.

Similar Initiatives. A few other states have received permission from HCFA to expand Medicaid eligibility for children under the 1902(r)(2) option, including Washington, Delaware, and Minnesota. *Washington* recently converted its state-funded insurance program to Medicaid by expanding Medicaid eligibility up to the FPL for children through age 18. *Delaware* uses Medicaid to help finance coverage for children through age 17 with family incomes below the FPL, under its new children's health insurance initiative.

Minnesota. Minnesota received permission from HCFA to expand its Medicaid eligibility to 275 percent of the FPL for children through age 18 and pregnant women, effective July 1, 1993. The expansion first needs legislative approval and some policymakers express concern over added costs. Although the new MinnesotaCare program (see the "Insurance" section) excludes insured persons, federal Medicaid regulations require states to cover all qualifying persons, whether insured or not. Medicaid then pays for covered services not included in an enrollee's insurance plan. This Medicaid policy would add more children to the pool of those eligible for state-funded coverage under MinnesotaCare. Also, Medicaid

regulations require states to cover certain services that may not be covered by a state-only funded plan, which would add additional costs. For example, the Minnesota Children's Health Plan does not currently cover inpatient care, but the Medicaid program requires such coverage. In addition, some persons fear that employers who now offer family coverage may cut either the family option or limit covered services, thus adding even more children to the state's program.

Wisconsin. Wisconsin's Healthy Start Program extends Medicaid benefits to uninsured or underinsured children up to age six and pregnant women with family incomes up to 155 percent of the FPL. Healthy Start operates as a demonstration program under a federal "section 1115A waiver," which allows the secretary of health and human services to authorize demonstration projects. The program has no assets limit, and certain expenses may be deducted in determining eligibility, such as child care and family medical costs. Persons apply through county social services or income maintenance agencies. A formal program evaluation, due in January 1994, will examine program results, including information about access barriers and enrollee characteristics. Contact: Wisconsin Department of Health and Social Services, P.O. Box 7935, 1 West Wilson Street, Madison, Wisconsin 53707; (608) 267-4525.

SCHOOL-BASED SCREENINGS, SERVICES, AND EARLY INTERVENTION

Program Highlight. Louisiana integrates a number of health and early intervention services through public schools. Under the state's EPSDT program, called "KIDMED," school nurses in almost one-half of Louisiana's school districts conduct preventive health screenings for Medicaid-eligible children. In addition, most public schools receive Medicaid reimbursement for health-related special education services and vision and hearing screenings. Many schools also provide early intervention services for eligible preschoolers through the "Childnet" program.

Legislation. No statutory reference exists for the EPSDT health screenings, although state law requires schools to screen children for vision and hearing problems every two years. State law governs the health-related special education services (La. Rev. Stat. 17:1941-1957) and the early intervention services for preschoolers (La. Rev. Stat. 17:1971).

Eligibility. All Medicaid-eligible children may participate in EPSDT screenings in schools that provide them. In Louisiana, Medicaid covers children ages six through nine in families with income up to the poverty level. For children ages 10 and older, Medicaid eligibility is tied to the state's Medically Needy program, for which income for a family of three may not exceed 26 percent of the poverty level. In 65 of the state's 66 school districts, schools receive Medicaid reimbursement for eligible children who obtain health-related special education services.

For children ages three to five who have disabilities, schools provide health and other support services under Part B of the federal Individuals with Disabilities Education Act (IDEA). Part B, formerly known as the Education for All Handicapped Children Act of 1975, requires states to ensure that all eligible children with disabilities, beginning at age three, receive a free and appropriate public education. Medicaid reimburses for health-related services under the preschool program for Medicaid-eligible children with family incomes up to 133 percent of the FPL.

Infants and toddlers with disabilities receive early intervention services under Part H of IDEA, the federal Program for Infants, Toddlers, and Families. Participating schools in Louisiana provide early intervention services to infants and toddlers who meet the disability criteria. About 50 percent of Louisiana infants and toddlers in the state's early intervention program qualify for Medicaid, which covers the health-related services. In order to receive Medicaid reimbursement for early intervention evaluations, therapies, and other necessary health services, children must first be screened by a physician.

Administration. Medicaid of Louisiana administers the state's EPSDT program. Almost one-half of Louisiana's school systems serve as EPSDT providers for medical screenings through their school nurse programs. The state contracts with an independent firm to manage recipient outreach, provider recruitment and enrollment, screening administration, service coordination, and provider monitoring. Schools either bill Medicaid electronically for services or use a contractor to take care of the billings. Medicaid of Louisiana supplies school systems with a monthly Medicaid eligibility listing to assist in outreach efforts.

The Medical Assistance Program provides coverage for screenings, evaluation, diagnosis, and treatment of children with disabilities and those who receive

health-related special education services within the framework of the EPSDT services. The Department of Education coordinates Childnet, the state's Early Intervention Program for Infants and Toddlers. State education agencies identify, through screening and assessment, children with disabilities or developmental delays, and furnish services to meet their needs. Physicians, other health care professionals, the state's "Child Search" program, and other public outreach efforts help identify infants, toddlers, and preschoolers with disabilities for referral to early intervention services. The Child Search coordinator in the local school system serves as the point of entry for needed services.

Implementation. Louisiana's school-based EPSDT screening experience spans 20 years. After authorization by Congress in 1988, Louisiana became the first state to expand its EPSDT discretionary services to allow local schools to use Medicaid for health-related special education services for eligible children. The state expanded services to children with special needs to include early intervention services for infants and toddlers in July 1990.

Services. School nurses in participating districts perform EPSDT screenings for preventive medical, vision, and hearing checks. The nurses determine whether to refer children for further diagnosis, evaluation, or treatment. The medical screening includes the following: a comprehensive health and developmental history, including assessment of physical and mental development and nutritional status; a comprehensive unclothed physical examination and assessment; immunizations or referral for immunizations; laboratory procedures, such as a urine test, if needed; health education, including anticipatory guidance; and care coordination. If a screening indicates a need for further diagnosis or treatment, the nurse refers the child to a local physician, other health provider, or perhaps a special education coordinator. Both the EPSDT screening provider and the KIDMED administering agency must follow up to ensure that the child receives the needed services.

Several school-based clinics that serve primarily adolescents and provide KIDMED screening services use a variety of providers, including physicians, nurse practitioners, social workers, and psychologists.

For preschoolers and school-aged children with special health care needs, schools may be reimbursed by Medicaid for the following services: health-related special education services, including

audiology and speech evaluations and therapy; psychological services; physical and occupational evaluations and therapy; and diagnostic or evaluative services. Speech therapy accounts for more than 80 percent of the health-related special education services billed to Medicaid. Infants and toddlers usually receive health services such as occupational therapy and physical therapy in settings outside the school. Medicaid has enrolled more private providers for early intervention services, especially for family services coordination, because many local schools lack the necessary qualified professionals and financial resources.

Funding. Using school nurses for EPSDT screenings and other Medicaid-reimbursable services allows Louisiana to receive a three-to-one federal match for school-based health services it otherwise would fund with only state money. The state spends about \$6 million annually in state and federal Medicaid dollars for EPSDT health services. The KIDMED screening services in schools accounted for \$2.7 million in FY 1992. Schools receive \$68 for each screening completed. In 1990-91, Medicaid paid for \$5.4 million in health-related special education services provided through participating schools.

Evaluation. Approximately 20,000 school-aged children received KIDMED medical screenings in

30 participating school nurse programs in the 1991-92 school year. The comprehensive EPSDT health screenings may be the only source of health care for thousands of children who have no primary care physician. School-based screenings helped the state increase its EPSDT screening rate from 33 percent of the goal in 1989 to more than 50 percent in 1992. Participating schools achieve screening rates as high as 60 to 80 percent for their eligible children. Program advocates view the coordination between Medicaid and local schools as a way to improve access to preventive care for healthy children and treatment for children with special health care needs.

Program Limitations or Concerns. Because of Louisiana's low Medicaid eligibility threshold for youth over age nine, fewer middle school and high school students receive medical screenings. Clinics in those schools receive no state aid and could benefit from Medicaid funding. Some health care providers believe that school-based health services compete with community-based providers. Also, they argue that schools cannot serve adequately as a "medical home" for children to meet their comprehensive health care needs on a 24-hour basis.

Contact: Medicaid of Louisiana, Department of Health and Hospitals, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030; (504) 342-3881.

Special Health Care Needs

BACKGROUND

Between 10 percent and 15 percent of American children have a chronic health condition, such as diabetes, asthma, a heart condition, multiple sclerosis, or other illness. About 5 percent have serious health care needs, and between 1 and 2 percent have severe impairments that may require special medical services and attention throughout their lives.³¹ For example, a child with cerebral palsy, mental retardation, and cortical blindness requires a variety of health and social services. Although the number of children with special health care needs is relatively small, they consume an estimated 25 percent to 50 percent of all child health care expenditures.

Families who have a member with special health care needs cope with extraordinary circumstances, financial costs, emotional stress, and time demands. When a child requires specialized care around the clock, a parent often becomes the full-time caretaker, quitting a job if necessary. Families who have uninsured children with special health care needs face the double dilemma of paying for expensive services and the likelihood of never obtaining private insurance coverage for that child. Even families who thought they had excellent insurance coverage may face exorbitant increases in premiums, exclusions for expensive services and equipment, loss of coverage after reaching the lifetime expenditure cap, and inability to move or change jobs for fear of losing employer-based coverage.

Without needed support systems and services, families may face the difficult emotional choice of placing a member in an institution or other out-of-home setting, usually at great economic cost to the state. In some cases, families impoverish themselves to qualify for Medicaid assistance or give up guardianship to receive services.

Many preventable problems are caused by maternity complications, premature births, and high-risk behavior by pregnant women, such as smoking, drinking, and using illegal drugs. Medical screening and intervention, patient education, substance abuse treatment, nutrition counseling, and transportation to services are among the comprehensive prenatal care services that can help prevent many complications leading to disabilities. For example, high blood

pressure, maternal infection, and elevated blood sugar all may be treated to help prevent complications. Fetal alcohol syndrome caused by alcohol abuse during pregnancy is a leading cause of mental retardation. The federal *Healthy Children 2000* goals relating to maternal and infant health state that 90 percent of pregnant women should receive prenatal care in the first trimester, should be offered screening and counseling about prenatal detection of fetal abnormalities, and should receive risk-appropriate care.³²

Screening newborns for genetic disorders helps identify treatable conditions such as sickle cell anemia, galactosemia, and PKU, all of which can contribute to premature death or severe disability. *Healthy Children 2000* goals call for at least 95 percent of newborns to be screened for genetic disorders and at least 90 percent of those who test positive to be treated.³³ Early intervention services help prevent or reduce the effects of disabilities or early developmental delays. Although further discussion of prevention efforts is beyond the scope of this publication, other NCSL publications address some of these issues.³⁴

A number of federal programs assist states in helping children with special health care needs and their families. This section briefly highlights provisions under Part H of the Individuals with Disabilities Education Act, the Maternal and Child Health Services Block Grant program (Title V of the Social Security Act), and Medicaid.

Part H Early Intervention Services. Part H of IDEA provides financial assistance to help states develop and implement a program of early intervention services for infants and toddlers with developmental disabilities or with conditions that place them at risk of developmental delays. This discretionary program encourages states to develop "statewide, comprehensive, coordinated, multidisciplinary interagency programs" to meet the needs of children and their families.³⁵

Title V MCH Block Grant. The federal Maternal and Child Health Services Block Grant program, also referred to as "Title V," helps states provide services to low-income children and pregnant women as well as other persons who require medical care. Under their MCH block grant programs, states provide matching funds for federal dollars received and must allocate at least 30 percent of the block grant funds for services to children with special health care needs.

The federal MCH block grant legislation passed in 1989 requires such state programs to promote comprehensive, community-based, coordinated, and family-centered service systems.³⁶ For example, *South Dakota's* Youth and Family Alliance provides leadership in the development of a statewide system of local interagency coordination networks. The alliance, created by the governor to coordinate state services for youth from birth through age 21, meets monthly and has upper-level managers from the following agencies: the Governor's Office, the Unified Judicial System, the Attorney General's Office, the Office of Indian Affairs, and the Departments of Health, Education and Cultural Affairs, Human Services, Social Services, Corrections, Labor, and Commerce and Regulations.

Among other duties concerning South Dakota's youth, alliance members collaborate to serve children with special needs, or who are at risk of disabilities. The alliance develops state policy and planning for coordinated service delivery, and directs the activities of five regional interagency facilitators funded by several participating agencies. The facilitators, located strategically around the state, serve as liaisons between the state agencies and the local networks, offering technical assistance and information pertinent to the local networks. The local networks, composed of a variety of community leaders, service providers, and service consumers, provide a single point of contact for families. They also work to identify service needs, eliminate unnecessary duplication, coordinate existing services, and collaborate to use resources. The state and local networks coordinate their MCH block grant initiatives with their Part H programs and with programs funded under the federal Child and Adolescent Service Systems Program (CASSP) for youth with serious emotional disturbances. Contact: South Dakota Department of Health, Maternal and Child Health Program, 445 E. Capitol, Pierre, South Dakota 57501-3185; (605) 773-4476.

Medicaid. Recent expansions and revisions in federal Medicaid requirements make the program a significant resource for low-income children with special health care needs. With expansions in income standards, as described in the "Medicaid" section, the program covers many more children now than when eligibility was tied to other public assistance programs such as AFDC.

In addition, OBRA-89 requires states to cover expanded treatment services under their EPSDT programs. States must now provide any Medicaid-reimbursable medically necessary treatment to correct or ameliorate any physical or mental

problems identified during EPSDT screenings and assessments. The treatment requirement applies to all Medicaid-reimbursable services under the federal guidelines, including optional services not otherwise covered under a state's regular Medicaid plan, such as physical therapy, case management, respiratory care services, and private duty nursing. Refer to the "Medicaid" section for further description of EPSDT and state initiatives under Medicaid.

In November 1991, advocates sued Pennsylvania for negligence because of its alleged slow response to the federal requirements to actively seek out eligible children, enroll them in EPSDT, and provide necessary treatment services. Plaintiffs also charged the state with not providing the Medicaid population equal access to providers because of low reimbursement rates for pediatricians and obstetricians. The case, *Scott, et al. v. Snider, et al.*, continued in settlement negotiations at the time of this publication. Other states may learn how to improve their own EPSDT outreach and treatment programs from the Pennsylvania case.

In addition to providing EPSDT services to a greater number of eligible children, states have other options under Medicaid to assist more children with special health care needs, including the following:

- The Home- and Community-Based Services waiver, also known as the "2176 waiver," allows states to cover certain home- and community-based nonmedical support services to Medicaid-eligible persons who otherwise would be served in an institutional setting at an equal or higher cost. As of 1992, 47 states offered services under 2176 waivers, such as case management, respite care, habilitation, and in-home personal care services.
- The Model Waiver Option allows states to cover optional services that are not otherwise in its Medicaid plan for a small targeted group of persons, such as children dependant on a ventilator. This waiver, sometimes called the "50/200 waiver," allows Medicaid reimbursement for home care services to a defined population of up to 200 persons per waiver who otherwise would need more costly institutional care.
- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allows states to offer Medicaid services without considering family income for children with severe disabilities who live at home. For children under age 18 with disabilities, states usually consider

parental income when determining a child's eligibility for Medicaid benefits, unless the child is removed from the family setting. Although approximately one-third of states use the TEFRA option, most apply it to a very narrow range of potential beneficiaries. Numbers of children covered in 1990 ranged from two in *South Dakota* and *West Virginia* to 1,515 in *Wisconsin*. Wisconsin publicizes its TEFRA option and conducts outreach to families who may be eligible.³⁷

STATE APPROACHES

Although all states sponsor some assistance for children with special health care needs, many services are based on eligibility for categorical programs such as Medicaid or other assistance based on income or a particular diagnosis. Very few states support programs designed to meet the needs of the full range of children who have special health care needs. Approaches highlighted in this section include state-sponsored health insurance in *Massachusetts*, catastrophic health insurance in *New Jersey*, and family support services in *Michigan*. The *Louisiana* example in the "Medicaid" section describes the state's initiative to capture Medicaid funds for EPSDT screenings, health-related special education services, and early intervention services provided in public schools. In addition, some of the state insurance initiatives described under "Insurance" cover services for children with special health care needs. For example, the *Pennsylvania* Child Health Care Act prohibits health plans under the act from excluding pre-existing conditions.

STATE-SPONSORED INSURANCE PROGRAM

Program Highlight. The Massachusetts Common Health Program for Working Adults with Disabilities and Disabled Children provides full or supplemental health care benefits to children and working adults with disabilities. Participants pay a premium, determined by family income. As a Medicaid "buy-in" program, it provides comprehensive insurance for those who have none and supplemental coverage for those who have some benefits.

Legislation. The Massachusetts Health Security Act of 1988, known as "CommonHealth," was heralded as the nation's first universal health care initiative. Although the legislation applies to the state's entire uninsured population, most provisions are "on hold" because of the state's budget problems and political

turnover. The surviving first phase of the comprehensive CommonHealth legislation includes the Medicaid "buy-in" program for qualifying children and working adults with disabilities (Mass. Gen. Laws Ann. ch. 118E, secs. 6A and 6B and ch. 118F, sec. 19).

Eligibility. To participate, children must meet SSI disability standards, but not be eligible for Medicaid or SSI because of income or assets. Qualifying parents with employment-based insurance must first purchase their employer's minimum health insurance package if it covers their child's pre-existing condition. They may then purchase supplemental insurance under CommonHealth for medical services and equipment not covered by the employment-based plan.

Administration. The Department of Public Welfare administers CommonHealth, determines eligibility, and bills participants for monthly premiums. Services are available through participating private physicians, neighborhood health centers, and hospitals.

Implementation. The first phase of the original comprehensive CommonHealth initiative began on July 1, 1988, covering children and working adults with disabilities, people who leave welfare to work in jobs without health insurance benefits, and low-income pregnant women and young children. The program currently serves 1,600 children with special health care needs.

Services. For children with disabilities, CommonHealth covers a wide range of health services, most of which have the same benefits and limitations as the state's Medicaid program. Covered services include outpatient and inpatient hospital and clinic visits; treatment from physical, occupational, and speech therapists; home services, including personal care attendants and skilled nursing services; outpatient mental health services; durable medical equipment; early intervention services; dental care; laboratory services; and prescriptions. The state's Title V maternal and child health program for children with special health care needs provides case management for participating families.

Funding. The original CommonHealth "play or pay" requirement for employers to provide insurance or pay an amount to the state remains on hold. Funding for the existing program for children with disabilities consists of \$15 million in FY 1992 from the general fund. In addition, participating families pay monthly premiums based on ability to pay, which currently range from a low of \$6 to

\$300. Periodic revisions occur in the premium structure.

Evaluation. No formal program evaluation exists. CommonHealth operates as a health insurance buy-in program for qualifying families who need insurance coverage for their children with special health care needs. No good estimate exists for families in the state who may qualify for participation.

Program Limitations or Concerns. Some persons believe that using SSI disability standards for program eligibility excludes many families who could benefit from the program. As with other health insurance programs, cost remains a constant concern, especially for extraordinary services. CommonHealth supplements some participants' "normal" private insurance policies, paying for expensive services not covered by their insurance plans. Some persons question whether "normal" policies cover enough services, or perhaps whether the CommonHealth package covers too many services. Program personnel must balance the needs of families with a concern about overuse of expensive services.

Contact: CommonHealth Central Office, Department of Public Welfare, 600 Washington Street, 5th Floor, Boston, Massachusetts 02111; (617) 348-5059.

Similar Initiatives. About one-half of states now have high-risk pools to assist persons considered "high risk" or "uninsurable" by the private insurance industry. States subsidize group coverage for participants, usually by taxing insurance companies in the state. Although these pools provide much-needed coverage for persons able to participate, their high costs, even with a subsidy, preclude many others from participating. Premiums paid by participants usually run 25 to 50 percent higher than average insurance coverage, and many policies have high deductibles and copayments. Most risk pools also require a waiting period of six to 12 months before pre-existing conditions may be covered.

CATASTROPHIC INSURANCE

Program Highlight. New Jersey's Catastrophic Illness in Children Relief Fund provides financial assistance to families whose children have extraordinarily high medical expenses not covered by private insurance or a government program.

Legislation. Signed into law in January 1988, the Catastrophic Illness in Children Relief Fund legislation created a governing commission to oversee an assistance program for eligible families (N.J. Stat. Ann. 26:2-148 et seq.).

Eligibility. Families may apply for assistance if their child's medical expenses exceed 30 percent of income under \$100,000, or 40 percent of income over \$100,000. To qualify, expenses must occur in a prior consecutive 12-month period. Expenses and income are measured for the same time period. Parents (or legal guardians) must be state residents for at least six months prior to submitting an application.

Administration. The Catastrophic Illness in Children Relief Fund Commission governs the program and authorizes payment for certain medical expenses of eligible families. The commission works with the Title V Special Child Health Services case management units in each county. The local units conduct outreach, provide additional information about the fund, refer families to other resources for which they appear eligible, and forward applications to the state-level commission office. Commission staff screen all applications for eligibility and work with families to verify income and expenses.

Services. The following medically authorized services may be considered for reimbursement under the fund: primary care; specialized pediatric ambulatory or home care; care in acute or specialized hospitals; pharmaceuticals; disposable medical supplies; durable medical equipment; family medical transportation; hospice or respite services; treatment for mental health, substance abuse, or other addictive disorders; home modifications; temporary shelter costs when a family relocates for treatment; and up to 50 percent of health insurance premiums paid directly by the family. The program allows special review of a request for experimental treatment or drugs. In addition, the commission may purchase a one-year health insurance policy for eligible uninsured families.

Funding. To fund the program, the legislature enacted a \$1 annual surcharge per employee for all employers under the state's Unemployment Compensation Law. Approximately \$5 million per year goes into the trust fund. Participating families pay a portion of their child's health care expenses, with an exemption for hardship cases.

Evaluation. As of December 1992, the program had assisted 330 families financially, expending \$6.6 million. Allocations range from \$476 to \$564,695, with an average award of \$20,778. Family income for participants has ranged from no income to \$99,256, with an average of \$22,631. In the first year of operation, participating families spent an average of 72 percent of their income on health care for their children. By 1992, the average medical costs of participating families exceeded family incomes, averaging 135 percent. The program also has provided information and referral services to another 210 families.

Program Limitations or Concerns. In reviewing applications from families, the commission realizes that many families who do not meet the program's financial requirements nonetheless face financial hardships in paying for their children's medical care. To address the apparent need of more families, the commission supports pending legislation to lower the eligibility threshold from 30 percent to 15 percent of income spent on medical care.

Contact: Catastrophic Illness in Children Relief Fund Commission, New Jersey Department of Health, CN 364, Trenton, New Jersey 08625-0364; (609) 292-0600.

Similar Initiatives. A few other states have addressed extremely high-cost medical care associated with catastrophic illness through state-sponsored insurance plans, but only New Jersey's applies specifically to children. Most other programs experienced high costs and utilization, and the states have reduced or eliminated their programs in tight budget times. *New York* activated its Catastrophic Health Care Expense Program on a pilot project basis in 1988, after years of not funding the statutory program. Demonstration projects in three counties assist individuals and families who have catastrophic expenses to forestall them from reducing their income and assets to qualify for Medicaid. As of June 1992, about 700 households had been helped, and program applications will be taken through June 1994. A program evaluation will help determine whether the program will continue or expand in the future. Contact: Department of Social Services, Division of Health and Long Term Care, 40 North Pearl Street, Albany, New York 12243; (518) 474-9130.

FAMILY SUPPORT

Program Highlight. Michigan's Family Support Subsidy Program provides monetary assistance to

eligible families who care for a child with severe disabilities. In addition, families in the subsidy program, as well as other families caring for a child with disabilities, may receive a variety of family support services.

Legislation. In 1983, the Michigan Legislature required the Department of Mental Health to establish a Family Support Subsidy Program. Designed to help keep families together and to promote the return of children in state institutions and foster care to their families, the program defrays some of the special costs of caring for a child with severe disabilities (Mich. Comp. Laws Ann. sec. 330.1155 et seq.). Additional family support services were developed under the general statutory authority of the Department of Mental Health.

Eligibility. Families with incomes below \$60,000 may be eligible for the Family Support Subsidy Program if their child lives at home, is under age 18, and meets certain disability standards for children with severe developmental disabilities. Public school district multidisciplinary teams evaluate children for disability criteria based on an educational classification of "severely multiply impaired," "severely mentally impaired," or "autistic impaired."

Families who receive the subsidy and others who have a child with special health care needs may receive family support services on an income-based sliding scale. A special exception exists for respite care, for which all eligible families pay very little.

Administration. The state Department of Mental Health administers the family support subsidy and other statewide family support services, in conjunction with 55 county Community Mental Health (CMH) programs. Local CMH programs conduct outreach with neonatal clinics, schools, local physicians, and local public health agencies. CMH programs also coordinate family support services with other programs, such as public health and social services agencies. Families report in writing at least annually to Community Mental Health programs about using the money to meet their special needs.

Implementation. Michigan's family support initiative began as a pilot project in 1980 and became a statewide program with passage of legislation in 1983.

Services. Families eligible for the family support subsidy receive a monthly cash payment, which was originally based on Supplemental Security Income

guidelines. Eligible families received payments of \$256.74 per month in 1990, but the subsidy was reduced in both 1991 and 1992 in response to the state's budget problems. Eligible families currently receive \$222.11 per month to help defray costs associated with caring for their child, such as buying specialized equipment, making home modifications, and paying for respite care. Parents of a child living in an out-of-home placement may receive a one-time lump sum advance payment of twice the monthly family subsidy to help prepare to bring their child home to live.

In addition to the cash subsidy, Michigan also provides other family support services, both to families in the subsidy program and others who do not qualify for the cash assistance. Services include case management; respite and sitter services; parent training and education; physical, speech, and occupational therapies; financial services; assessment and evaluation; therapeutic mental health; support groups; and crisis intervention.

Funding. The Family Support Subsidy Program's FY 1992 budget was \$11.1 million through the Department of Mental Health. As of the end of FY 1992, about 3,980 families were receiving family support subsidy payments. When funding appropriated by the legislature does not meet program needs, the Department of Mental Health may reduce family payments by up to 25 percent in one fiscal year. Subsidy payments were cut 9.1 percent in 1991 and an additional 4.4 percent in 1992 in response to state budget problems.

Evaluation. The Department of Mental Health conducts annual evaluations and reports to the governor and legislature. Reports must include

information about participating families and the program's impact on the number of children with severe disabilities placed in foster care and state institutions. Since the subsidy program began in 1983, the number of children with disabilities in institutions decreased by 91 percent, from 175 to 15.

Program Limitations or Concerns. Because the subsidy program was created to assist families with children who have severe developmental disabilities, many families in similar situations do not qualify for help. For example, families with children who have severe physical disabilities or severe emotional disorders do not meet the program's eligibility criteria.

Contact: Department of Mental Health, Family Support Services and Subsidy, Lewis Cass Building, Lansing, Michigan 48913; (517) 335-4070.

Similar Initiatives. Although all states provide support services to some families who care for a child with disabilities and special health care needs at home, Michigan's program remains one of the most comprehensive. The most common state services include respite care to provide a break for family members; adaptive equipment, such as a wheelchair; and family counseling. Other common services include medical, health, and nutrition services; special clothing; recreation; speech, occupational, and physical therapy; home modifications or repairs; flexible payment for disability-related expenses; and case management. **Contact:** Human Services Research Institute (HSRI), 2336 Massachusetts Avenue, Cambridge, Massachusetts 02140; (617) 876-0426. (HSRI tracks state family support information.)

Immunization

BACKGROUND

Immunization may well be the single most cost-effective public health tool available in modern medicine. Recent outbreaks of vaccine-preventable diseases cost lives, cause disabilities, and cost money to treat. Reported measles cases reached 27,786 in 1990, more than 10 times the 1,497 cases reported in 1983. At least 130 persons died from measles-related complications during 1989-90, many of them children.³⁸ Policymakers are examining their own states' immunization rates and programs.

About 40 percent of American preschoolers are not fully immunized. The rate varies widely among states, localities, and population groups. An estimated two-thirds of urban preschoolers have not had all the recommended shots.³⁹ Although federal record-keeping of state-by-state immunization rates ceased after 1985, recent surveys from nine cities found that in the late 1980s, only 10 to 42 percent of children had completed the basic series of vaccines by their second birthday.⁴⁰ Adequacy rates for minority children are lower than for white children. A Chicago study in three schools revealed that 80 percent of children in the predominantly white school were adequately immunized by their second birthday, compared with only 50 percent in the schools with predominantly African American or Hispanic populations.⁴¹

Many variables affect immunization rates among children, including their insurance status or other ability to pay; accessibility of providers; accessibility of public clinics, including location, hours, and waiting time; and parental knowledge and motivation. Low immunization rates may also indicate problems in general health care services for children who lack the appropriate shots. Ideally, children should receive immunizations as part of their other well-child care services.

The federal *Healthy Children 2000* objectives call for at least 90 percent of children under age two to have the basic immunization series, with special efforts to target minority populations. In addition, finance and delivery systems should improve so that no American faces a financial barrier to receiving recommended immunizations.⁴²

Most states rely on "retrospective studies" of children entering school to determine vaccination rates. When immunizations are required for school entry, children's records should reveal if and when they received shots, although the information is sometimes lacking. A retrospective study of kindergarten records shows the immunization status of the five-year-olds when they were age two. This means accurate immunization data in most states are at least three years old.

In a retrospective study of 35,258 kindergarten records in 1990-91, the *Kansas* Department of Health and Environment determined that only 51.3 percent of the children were adequately immunized by age two. The department found a dramatic difference among counties, ranging from a low of 4 percent in one rural county to a high of 91 percent in its neighboring rural county. The "Similar Initiatives" section in the "Outreach and Education" program highlight briefly describes efforts to improve immunization rates in Kansas.

Federal Medicaid immunization standards follow the *Report of the Committee on Infectious Diseases* issued by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). Current standards recommend that children receive the immunizations listed below, most by age two.⁴³

State and local governments purchase approximately 25 percent of the total vaccines

Vaccine	Abbreviation	Doses
Diphtheria, tetanus, pertussis (whooping cough)	DTP	5
Poliomyelitis (polio)	OPV	4
Measles, mumps, rubella (German measles)	MMR	2
Haemophilus influenzae type b (for meningitis)	Hib	4
Hepatitis B	Hep B	3

administered annually in the United States. Federal funds purchase another 25 percent through the Immunization Grants Program, which assists states with their immunization programs.⁴⁴ The federal Centers for Disease Control, which administers the Immunization Grants Program, contracts with vaccine manufacturers for special reduced prices. These "contract prices" also are available to states that purchase vaccine in bulk. Health care providers purchase the remaining 50 percent of vaccines at the "catalogue" price. The following table compares the federal contract prices and the private purchase catalogue prices, per vaccine dose, as of March 1992.⁴⁵

Vaccine	Contract Price	Catalogue Price	Excise Tax*
DTP	\$1.69	\$5.41	\$4.56
OPV	1.80	9.62	0.29
MMR	10.89	20.85	4.44
Hib	4.75**	15.29**	0
Hep B	7.24	10.71	0

* The federal excise tax funds the National Childhood Vaccine Injury Act, which covers OPV, DTP, and MMR vaccines.

** The average price between the two manufacturers that make the Hib vaccine.

Vaccine prices skyrocketed in the mid-1980s, largely in response to lawsuits filed by persons allegedly injured by vaccines, especially pertussis. Manufacturers raised prices to cover litigation costs and injury claims. The catalogue price for DTP jumped from \$0.99 per dose in 1984 to \$11.40 per dose in 1986. After creation of the National Vaccine Injury Compensation Program in 1988, vaccine prices stabilized and even went down in some cases. The catalogue price for DTP dropped to \$5.41 per dose in 1992. With a federal excise tax of \$4.56 per dose to fund the federal injury compensation program, DTP doses now sell for \$9.97.⁴⁶ The *North Carolina Childhood Vaccine-Related Injury Compensation Program* complements the federal program, as described in the "Vaccine Liability Protection" section.

Using existing prices to compute the total vaccine purchase costs for the full series of recommended shots, the difference between the federal contract price (\$110.99) and the private catalogue price (\$233.36) is \$122.37 per child. These prices do not include an administrative fee for health care providers.⁴⁷

In addition to the vaccines purchased with CDC grant funds for use in public clinics, more than one-half of states purchase at least one type of vaccine in bulk through the CDC contract. About 15 states

purchase one or more vaccines for "universal" distribution to health care providers, illustrated by the *Rhode Island* example in the "Universal Access" section. At least another 16 states purchase vaccine in bulk for their Medicaid program, as illustrated in the *Ohio* example in the section on "Medicaid Bulk Purchase." For more information, refer to the "Similar Initiatives" sections after the *Rhode Island* and *Ohio* program descriptions.

Most other states reimburse health care providers on a fee-for-service basis for immunizing Medicaid-eligible children. Because private health care providers purchase vaccine at catalogue prices, their

costs and fees are higher than those who receive free vaccine from the state. The up-front costs associated with buying large quantities of vaccine, storing it, and distributing it around the state may inhibit many states that do not purchase vaccine in bulk. Even with those up-front costs, *Ohio's* program demonstrates significant cost savings for its Medicaid vaccine purchases.

State Medicaid reimbursement rates for vaccinations generally fall well below the usual fee charged by a private office-based provider. In 1991, among states that reimburse providers for vaccinations on a fee-for-service basis, the average Medicaid payments were the following percentage of the usual fee: 53 percent for DTP, 67 percent for polio, 72 percent for MMR, and 84 percent for Hib. In some states, Medicaid reimbursement rates do not even cover the cost of purchasing the vaccine.⁴⁸ In response to low reimbursement rates, some private providers send their Medicaid patients to public clinics to receive immunizations. This practice overloads the already crowded public clinics, disrupts continuity of care for the children, and causes some children to miss vaccinations when their families do not make the extra trips to obtain the shots.

The Clinton Administration proposes an additional \$300 million in federal funds next year to help vaccinate more children. The administration also

may propose universal bulk purchase at negotiated rates with drug companies to be able to distribute vaccines for all children. In addition, the federal government may create a national registry to track children's immunizations. Vaccine manufacturers register concern about the effect of lower government purchase prices on vaccine research and development.⁴⁹

STATE APPROACHES

High purchase prices, low reimbursement rates, and potential liability make many private providers reluctant to participate in public vaccination programs for Medicaid patients and other low-income children. These problems cause more patients to seek care at public clinics, many of which are already overcrowded. Examples in this section highlight efforts by states to improve immunization rates and alleviate problems of provider participation.

Rhode Island's universal access program provides free vaccines to all children who seek them from participating providers. *Ohio* distributes free vaccine to all Medicaid providers. *Colorado* requires parents to have their children immunized. *Oklahoma* conducts a public education and outreach campaign. *North Carolina* protects health care providers and vaccine manufacturers from liability for vaccine-related injuries.

As mentioned previously, only 47 percent of conventional insurance plans covered immunization costs in 1990. Coverage under health maintenance organizations is nearly universal. Some states require insurance plans to cover immunization costs, as illustrated by the well-child care mandates described in the "Insurance" section.

UNIVERSAL ACCESS

Program Highlight. Rhode Island purchases vaccine in bulk through the federal CDC contract and provides free vaccine to 13 hospital pharmacies. The hospitals, in turn, distribute vaccines to pediatricians who will administer them free, except for an administrative fee.

Legislation. Although the Rhode Island Department of Health purchased and distributed vaccines to pediatricians for many years without legislative mandate, the general assembly passed legislation in both 1991 and 1992 to expand the program. The

expansions added free access to a second dose of measles vaccine for children ages five to 12; four doses of the *Haemophilus influenzae* type b vaccine for infants; and three doses of hepatitis B for infants. Both the 1991 and 1992 laws provide a funding source for the expansions, as described under "Funding" (R.I. Gen. Laws sec. 23-4-6).

Eligibility. Any Rhode Island child may receive the covered vaccines free through a participating provider, except for an administrative fee. No income restrictions apply.

Administration. The Department of Health administers the program. Under the 1992 law, hospitals must administer childhood vaccinations without charge through their outpatient facilities, until June 30, 1993.

Implementation. The Department of Health has purchased and distributed polio, DTP, and MMR vaccines to providers for many years. Free distribution of the second measles vaccine and the Hib vaccines became effective in September 1991. Inclusion of hepatitis B began in December 1992.

Services. Any Rhode Island child may receive free DTP, MMR, polio, Hib, measles, and Hep B immunizations from a participating health care provider. Providers may charge a small administrative fee.

Funding. In FY 1992, the federal Centers for Disease Control funded 45 to 50 percent of Rhode Island's vaccine purchases. To pay for the expanded program, the 1991 legislation assessed an annual fee of \$50 on licensed physicians and 0.04 percent on insurance premiums. The 1992 legislation eliminated the fee paid by physicians and increased the assessment on insurers to 0.075 percent. In addition, the general assembly appropriated \$395,000 for the program.

Evaluation. State data show that 67.6 percent of Rhode Island two-year-olds are adequately immunized. Recent expansions were intended to add newly recommended immunizations to the state program and not necessarily to expand the number of children immunized.

Program Limitations or Concerns. Because Rhode Island targets most of its money to purchase vaccine, it supports very little outreach to increase its immunization rate. Neighborhood health centers often have a long wait for persons seeking an appointment. Also, many physicians are reluctant to serve simply as "vaccine factories" and want to

incorporate immunizations with more comprehensive well-child care. Although this preference represents the ideal in medical practice, it means that many low-income clients who cannot afford the more comprehensive services seek immunizations at overcrowded public clinics.

Contact: Rhode Island Department of Health, Division of Disease Prevention and Control, 3 Capitol Hill, Providence, Rhode Island 02908-5097; (401) 277-2577.

Similar Initiatives. In addition to Rhode Island, the following states purchase at least one vaccination for universal distribution: *Alaska, Connecticut, Hawaii, Idaho, Kentucky, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, South Dakota, Vermont, Washington, and Wyoming.*⁵⁰

MEDICAID BULK PURCHASE

Program Highlight. The Ohio Medicaid Vaccine Distribution Program purchases vaccines at bulk rates for distribution to Medicaid providers throughout the state.

Legislation. Although the Ohio Department of Human Services (ODHS) and the Ohio Department of Health (ODH) initiated the program, the general assembly revised appropriations to the departments to facilitate coordination between them and to provide up-front costs associated with purchasing, storing, and distributing vaccines.

Eligibility. Medicaid providers, including private practitioners, health maintenance organizations, and public health clinics, may order vaccine free from the state for their Medicaid-eligible patients. Covered vaccines include DTP, polio, MMR, and Hib. Under the program, public health clinics, including local health departments, became eligible to receive Medicaid reimbursement for vaccines administered to their Medicaid-eligible clients, representing about one-third of their patients. Medicaid-eligible children receive the covered immunizations free.

Administration. The Department of Health purchases, stores, and distributes vaccines for use by Medicaid providers. ODH also maintains computer records for administering the program and communicating with providers. As the state's Medicaid agency, the Department of Human Services finances the vaccines administered to Medicaid clients. Providers order vaccines from the Department of Health, based on their previous

Medicaid usage patterns. Providers then bill the Medicaid agency an administrative fee of \$2.07 for each dose of vaccine used for Medicaid-eligible patients. Providers continue to purchase vaccines for their private-pay patients from private distributors at the market price.

Implementation. When prices for vaccines jumped in 1986 (from \$4.29 to \$11.40 per dose for DTP and from \$6.72 to \$9.89 per dose for polio), representatives from the state departments of Human Services and Health met to discuss cost-saving alternatives to the existing vaccine procurement program. Since the state could purchase vaccine in bulk at much lower cost through the federal CDC contract with vaccine manufacturers, the departments developed an interagency agreement to establish and administer the Medicaid Vaccine Distribution Program. The program initially covered DTP, polio, and MMR vaccines, beginning in June 1987. Hib was added to the program in January 1991 after development of a vaccine suitable for infants, and Hep B may be added in the near future.

Services. The state purchases, stores, and distributes vaccines to participating health care providers for Medicaid-eligible clients.

Funding. Initiated as a cost-savings effort, the Ohio Medicaid Vaccine Distribution Program uses Medicaid funds to purchase vaccines in bulk through the federal CDC contract with vaccine manufacturers. Previously, the Medicaid program reimbursed health care providers for vaccines purchased at the market rate and administered to Medicaid clients. In addition, state funds used previously to purchase vaccines in public health clinics now are matched with federal Medicaid dollars for Medicaid-eligible patients. Private providers receive a \$2.07 administrative fee for each vaccine given to Medicaid-eligible patients. Although this sounds low, providers do not lose money on purchasing vaccines, as they do in some states that do not fully reimburse providers their purchase price for vaccines administered to Medicaid-eligible clients.

Evaluation. In its first six months, the Medicaid Vaccine Distribution Program saved approximately \$1 million in vaccine purchase costs. The annual net savings amounts to approximately \$2 million. The program calculates a difference of \$109.48 per child between the market price and the CDC contract price for a complete immunization series. With administrative costs of 3.9 percent for personnel, shipping, and storage, the state breaks even when

1,600 Medicaid-eligible children receive their appropriate shots. With more than 20,000 Medicaid-eligible children vaccinated in Ohio's private sector, the program's administrative costs total \$8.71 per child. Approximately 1,650 Medicaid providers participate in the program, up from 1,257 in its early years. The program has not experienced any shortages in available vaccines.

In addition to cost savings, the program results in better continuity of care by enabling more Medicaid-eligible patients to receive vaccines from their private providers. In states where providers receive inadequate reimbursement for vaccines, many send their Medicaid patients to public clinics. In Ohio, the free vaccine distribution to providers means less demand on public clinics.

Program Limitations or Concerns. Between 40 and 50 percent of Ohio's two-year-olds are not adequately immunized and the state continues to work on increasing its rate.

Contact: Medicaid Vaccine Distribution Program, Ohio Department of Health, 246 North High Street, P.O. Box 118, Columbus, Ohio 43266; (614) 466-4643.

Similar Initiatives. In addition to Ohio, the following states supply at least some vaccines purchased through the CDC contract to their Medicaid programs: *California, Colorado, Idaho, Illinois, Kansas, Kentucky, Michigan, Minnesota, Mississippi, Nevada, Pennsylvania* (a pilot project), *South Carolina, Texas, and Wisconsin*.⁵¹ Unlike Ohio, which provides vaccine to Medicaid providers through an "advanced ordering system," most other states that purchase Medicaid vaccines in bulk use a "vaccine replacement system." Under the replacement system, health care providers who administer vaccines to Medicaid-eligible children first purchase the vaccines at the higher catalogue price, administer them, report to the Medicaid program, and then receive vaccines to replace what they used for Medicaid patients.

Virginia recently contracted with the Vaccine Division of Merck and Co., Inc., to distribute MMR vaccines to state Medicaid providers. Merck ships vaccine to participating providers at no cost. Providers then submit invoices to the Department of Medical Assistance Services as the vaccine is used. Medicaid pays Merck for the vaccines at the CDC contract rate plus shipping costs. The state also pays providers a \$2 handling fee for each vaccine administered. *Virginia's* Direct Purchase Vaccine Program required a demonstration waiver from

HCFA so that Merck could be reimbursed directly for vaccines administered by Medicaid-enrolled health care providers. Contact: Department of Medical Assistance Services, Division of Policy and Research, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219; (804) 371-8850.

PARENTAL RESPONSIBILITY

Program Highlight. Under the Colorado Infant Immunization Program, parents (or guardians) have responsibility for getting their children vaccinated in compliance with the Board of Health's schedule of immunization. The Department of Health must provide, at public expense, "subject to available appropriations," systematic immunizations to infants who are not exempt from immunization requirements. Exceptions exist for medical, religious, and personal beliefs.

Legislation. The Colorado General Assembly passed the Infant Immunization Act in 1992 to require parents (or guardians) to take responsibility for immunizing infants. The act also requires the Department of Health to purchase and distribute vaccines without charge to practitioners who charge no more than an approved administrative fee and who participate in a state immunization tracking system. The law specifies limitations on liability for practitioners who administer vaccines properly. In cases where an infant was not immunized, such failure does not constitute sufficient grounds for insurance companies to deny a claim for a vaccine-preventable disease (Colo. Rev. Stat. sec. 25-4-1701 et seq.).

Eligibility. The immunization requirement applies to all infants (up to 24 months of age) who reside in Colorado, with the exceptions noted under "Program Highlight." The immunization program also applies to any Medicaid-eligible child who needs a vaccine, according to the schedule determined by the Department of Health. Beginning January 1, 1993, any infant or Medicaid-eligible child may receive vaccines at public expense, subject to available appropriations. Infants born on or after January 1, 1993, may participate in the state's new Infant Immunization Tracking Program. Practitioners who agree to administer vaccines without charge, except for an approved administrative fee, may participate in the program and receive free vaccine from the Department of Health.

Administration. The Colorado Board of Health, in consultation with the Department of Social Services,

promulgates rules to govern implementation and operation of the Infant Immunization Program. The Department of Health must do the following: determine which vaccines to require and at what frequency; purchase and distribute free vaccines to participating practitioners; establish a comprehensive immunization tracking system; and create an advisory committee to assist with educational outreach, annual reports, and regulatory recommendations. The state and local health departments must enroll infants born after January 1, 1993, in the state tracking system. Hospitals must distribute program information to all parents of newborns.

Implementation. The Infant Immunization Program began January 1, 1993.

Services. The Infant Immunization Program covers all vaccines recommended by the Department of Health, which also determines a frequency schedule. All infants (up to 24 months of age) and all Medicaid-eligible children who need the covered vaccines may receive them at state expense from participating providers, except for an administrative fee.

Funding. Legislation created the Infant Immunization Fund and transferred \$1.1 million from the Department of Social Services (state and federal Medicaid money) to the fund. The legislation also authorizes revenue from gifts, grants, or awards from the federal government or private sources to implement and operate the program. Because the general assembly appropriated no other funds to implement the program, only Medicaid-eligible children qualify so far.

Evaluation. According to state data, approximately 40 percent of Colorado's children under age two are not fully immunized. This data serves as a baseline for evaluating the Infant Immunization Program. Beginning January 1, 1994, the Department of Health must make an annual report to the general assembly detailing the effectiveness of the program.

Program Limitations or Concerns. Although the legislation appears to apply to all Colorado children up to age two, the limited Medicaid funds allocated for the program cover only Medicaid-eligible children for free vaccines. The Department of Health may solicit funds from other sources to expand the program. Some persons express concern about requiring parents by law to immunize their children without allocating funds to assist those who cannot afford the cost.

Contact: Epidemiology Division, Colorado Department of Health, 4300 Cherry Creek South Drive, Denver, Colorado 80222-1530; (303) 692-2669.

OUTREACH AND EDUCATION CAMPAIGN

Program Highlight. Oklahoma's "Due By Two" Campaign promotes vaccinations for children under age two through a multimedia advertising blitz. The campaign originally targeted one Saturday in October 1991 for children to receive free vaccines through community and public health centers. A three-month multimedia campaign (television, radio, newspapers, and billboards) promoted vaccinations.

Legislation. The legislature doubled the state appropriation for immunizations in FY 1992-93 in support of the executive branch initiative, bringing the state contribution to \$1.7 million.

Eligibility. During the "Due By Two" Campaign, all children who needed immunizations could receive them without charge at community and public health centers. Previously, county health departments charged an administrative fee for families with incomes in excess of 250 percent of the FPL. Perceived as a barrier to universal immunization, the Oklahoma Department of Health instructed county departments to drop the fee, beginning in April 1992.

Administration. Although the Department of Health administers the state's public vaccination efforts, the "Due By Two" Campaign was a collaborative effort. The department teamed up with Oklahoma's First Lady Rhonda Walters, an advocate for children's issues, and involved neighborhood and community health centers, the 70 county health departments, the Indian Health Service, hospitals and clinics, tribal health clinics, the media, and a variety of foundations and corporations. First Lady Walters served as the campaign spokeswoman and appeared in media spots. An advertised toll-free phone number referred persons to clinic locations.

Implementation. The "Due By Two" Campaign originated as an idea in July 1991, with an October Saturday chosen for free vaccines available at public clinics all over the state. The media advertising lasted nearly three months, with most children coming in for shots on the designated Saturday. Parents also responded by taking children to clinics

during the entire period of the media campaign. Organizers found the campaign so successful that "Due By Two" media spots continue to play periodically, and an expanded campaign is underway, called "Healthy Futures." Considered a broader "moms and kids" campaign, Healthy Futures focuses on prenatal care, substance abuse by pregnant women, child abuse, child safety, immunization, and other related issues.

Services. The "Due By Two" Campaign provided public education about immunization and free shots for Oklahoma children. Although planned as a one-time effort to increase immunization rates, the initiative's success prompted other media campaign and public education efforts (described under "Implementation"). The toll-free hotline now covers additional "Healthy Futures" topics. In May 1992, county health departments began immunization clinics one evening per week to expand community access. In addition, about 30 county departments now use computer tracking for children's immunizations, and other counties plan to start. Participating counties send out colorful reminder postcards when immunizations are due and "past due" postcards if parents do not respond to the first postcard.

Funding. The legislature doubled the state's appropriation for immunizations for FY 1992-93, adding \$860,000 in new money. The "Due By Two" media effort cost approximately \$419,000, using money from the Department of Health and donations from private companies and foundations. Contributions of air time and space from media sources resulted in actual advertising exposure worth about \$2 million.

Evaluation. Only about 33 percent of Oklahoma two-year-olds had received adequate immunizations before the "Due By Two" Campaign. An estimated 15,000 vaccinations were administered during the campaign at 109 clinic sites in 74 of the state's 77 counties. Private clinics also reported increases in immunizations during the campaign, although not funded by the state. Comparing immunization data from January to June 1991 and January to June 1992, Oklahoma witnessed a 31 percent increase in the number of children under age two who received a fourth dose of DPT vaccine. Even though the campaign targeted children under age two, older children also benefited. The vaccine rate for children under age five increased by 11 percent during the same time period. The expanded "Healthy Futures" campaign resulted in more than 100,000 phone calls in the first 12 months. Oklahoma wants to be the first state to reach the

federal *Healthy Children 2000* goal of having 90 percent of children under age two adequately immunized.

Program Limitations or Concerns. Campaign organizers anticipated difficulty in coordinating the multiple agencies, volunteers, and media, but managed to complete the campaign successfully. Some health care providers register concern about isolating immunizations from more comprehensive well-child care services, and also whether children receive adequate follow-up to initial vaccines.

Contact: Oklahoma Department of Health, 1000 NE 10th, Oklahoma City, Oklahoma 73117-1299; (405) 271-4200.

Similar Initiatives. As mentioned previously, the Kansas Department of Health and Environment found wide disparities among counties in their immunization rates, ranging from a low of 4 percent in one county to a high of 91 percent in another. Kansas Action for Children, Inc., teamed up with local health departments in 1991 to raise public awareness about the need for timely immunizations. Joined by local Kiwanis Clubs in 1992, the coalition launched a statewide media campaign with radio spots, billboards, and posters. Campaign materials featured a dinosaur logo with the slogan, "Childhood Diseases Are Not Extinct." Contact: Kansas Action for Children, Inc., P.O. Box 463, Topeka, Kansas 66601; (913) 232-0550.

VACCINE LIABILITY PROTECTION

Program Highlight. North Carolina's Childhood Vaccine-Related Injury Compensation Program protects health care providers and vaccine manufacturers from liability for vaccine-related injuries and compensates children injured by vaccinations.

Legislation. The North Carolina General Assembly established the Childhood Vaccine-Related Injury Compensation Program in 1986 to address several concerns: high costs associated with injury claims; a decline in the number of physicians willing to administer vaccines, especially for pertussis (whooping cough); a dramatic increase in vaccine prices by manufacturers concerned with liability claims; and a dramatic rise in the number of children seeking publicly funded vaccinations due to high prices in the private sector. In response to a large judgment against a pediatrician in 1986, the North Carolina Pediatric Society teamed up with the Department of Environment, Health and Natural

Resources to promote tort reform for vaccination liability (N.C. Gen. Stat. sec. 130A-422 et seq.).

Eligibility. Under the 1986 law, any person who believes he or she has been injured by a vaccination required by the state may file a claim for compensation within six years of receiving the vaccine. Once the National Childhood Vaccine Injury Act (P.L. 99-660) was passed by Congress to cover vaccinations administered after October 1, 1988, North Carolina residents could choose between filing a claim with the state or the federal government. State legislators amended the North Carolina law in 1991 to require claimants to first file a claim under the federal program for the three vaccinations it covers: DTP, MMR, and polio. If not satisfied with the federal decision or award, or if a claim alleges injury from another vaccination required under state law, such as Hib, North Carolina claimants may file directly with the state. If the state requires infants to get the hepatitis B vaccine, as expected, it also would come under the state program.

Persons allegedly injured by a voluntary vaccination, such as a flu shot or immunizations for overseas travel, may not file under the state program. Claimants need not prove negligence under either the state or federal programs; they simply need to show that the injury resulted from the vaccination.

Administration. Eligible claimants file for vaccine-related injury compensation with the state's Industrial Commission, which also hears workers' compensation claims. Because state law prohibits claims against health care providers and vaccine manufacturers, the claim is against the state. The Department of Environment, Health and Natural Resources represents the state and decides whether to recommend compensation or fight the claim. The state's motivation to protect providers and manufacturers and to compensate vaccine-injured children makes the process less adversarial than typical suits against the state. If the department recommends compensation, the Industrial Commission determines the award. If the department believes the alleged injury is not vaccine-related, it fights the claim before a commissioner, who hears arguments, reviews each case, and either makes an award or rejects the claim.

A dissatisfied claimant may appeal to the full Industrial Commission, which must hear the appeal and decide the case. Only after a ruling by the full commission may a claimant appeal for errors of law to the state Court of Appeals. When the state

believes injury was caused by negligent handling or administration of a vaccine or by negligence of a manufacturer resulting in a defective product, the state may sue for damages.

Implementation. As described under "Eligibility," the North Carolina program changed after enactment of the National Childhood Vaccine Injury Act. Since 1986, only about 16 to 18 claims have been filed. Because most claimants must now file first with the federal program, North Carolina expects few, if any, new claims. State policymakers agree that the program should remain in place, however, to protect health care providers and vaccine manufacturers from claims allowed against them under the federal law if a claimant is not satisfied with the outcome, or if a claim concerns a vaccine not covered under the federal program. Proponents view it as a vital protection that now costs very little.

Services. The Industrial Commission may award compensation for actual and projected reasonable expenses for medical and support services, loss of earnings, noneconomic damages for pain and suffering, attorney fees, and to meet needs determined on a case-by-case basis by the secretary of the Department of Environment, Health and Natural Resources. The law prohibits punitive damage awards and limits monetary awards to no more than \$300,000. The department must develop a comprehensive, coordinated plan of care for injured claimants who need medical, health, or developmental evaluation; special education; vocational training; physical, emotional, or behavioral therapy; residential and custodial care; and other related services. Instead of making a monetary award to cover needed services, as in the federal program, the state's program requires the department to provide needed services to injured claimants, even though they may not otherwise meet eligibility requirements for such services. The value of services sponsored by the department does not count toward the monetary award limitation.

Funding. No separate appropriation exists for the Childhood Vaccine-Related Injury Compensation Program. Monetary awards must come from surplus funds of the Department of Environment, Health and Natural Resources that would otherwise revert to the general fund. So far, surplus funds have covered all award costs. The requirement to provide needed medical and support services through existing state programs saves the state money that would otherwise pay for such services in the private sector.

Evaluation. Although no formal evaluation of the program exists, those involved agree that it provides needed protections for health care providers, vaccine manufacturers, and injured children. Providers and manufacturers no longer fear malpractice suits; vaccine prices have stabilized; and fewer children who receive care from private practitioners are forced to seek vaccinations in public clinics.

Program Limitations or Concerns. Some persons close to the program believe the statutory language contains some discrepancies and could be improved.

Contacts: Department of Environment, Health and Natural Resources, 512 N. Salisbury Street, Raleigh, North Carolina 27611; (919) 733-4984. North Carolina Industrial Commission, 430 N. Salisbury Street, Raleigh, North Carolina 27611; (919) 733-4820.

Similar Initiatives. Because the national program exists, most states do not have a vaccine-related injury compensation program. However, claimants under the federal program may sue health care providers or vaccine manufacturers if dissatisfied with the federal outcome, or if their injury stems from a vaccine not covered under federal law, such as the Hib and Hep B vaccines. North Carolina program advocates and the American Academy of Pediatrics encourage enactment of state programs to supplement the federal law. AAP developed a model bill and information packet for states interested in pursuing such legislation.

Contacts: American Academy of Pediatrics, Division of State Government Affairs, 141 Northwest Point Boulevard, P.O. Box 927, Elk Grove Village, Illinois 60009; (708) 228-5005. National Vaccine Injury Compensation Program, Health Resources and Services Administration, 6001 Montrose Road, Room 702, Rockville, Maryland 20852; (301) 443-6593.

Adolescent Health

BACKGROUND

With public policy emphasis on improving birth outcomes and meeting the health needs of young children, the special needs of adolescents often go unnoticed unless major problems arise. Teen pregnancy, substance abuse, accidents, and violence represent the most visible problems associated with this age group. But teens have other health care needs as well.

About 16 percent of the 16.6 million American youth ages 13 to 17 lack health insurance. As with other uninsured children, a disproportionate share of uninsured adolescents are poor and members of a minority group. Approximately 32 percent of youth ages 13 through 15 with family incomes below the FPL are uninsured, and 30 percent of the age group with family incomes between the poverty level and 150 percent of the FPL lack insurance coverage.⁵² Because eligibility is tied either to the AFDC or Medically Needy program, state Medicaid eligibility levels for youth over age nine generally are much lower than for younger children, as seen in table 2.

The federal Office of Technology Assessment reports that as many as 20 percent of today's 31 million adolescents have at least one serious health problem.⁵³ As do other Americans, adolescents also need basic primary and preventive health services. A study of the Minnesota Children's Health Plan (see the "Insurance" section) revealed that 17-year-olds were the most costly age group covered in 1991. The major expenditures for this group included vision problems, eyeglasses, respiratory illnesses, injuries, prescription medications, and dental care. Eligibility for Minnesota's program expanded in 1991 to include youth ages nine through 17, which may explain the relatively large utilization rate of services by 17-year-olds. They became newly eligible for services in 1991, but eligibility expired on their 18th birthday. The demand for services may reflect their unmet needs.

All states share the issue of unwanted teen pregnancies. State policymakers also face disagreement among citizens about government's appropriate role. This publication briefly addresses the teen pregnancy issue. Although many other areas of concern exist for the adolescent population, further discussion of issues related to substance

abuse prevention and treatment, injuries and deaths caused by violence, and the spread of acquired immune deficiency syndrome (AIDS) among teens is beyond the scope of this publication. The appendix and the annotated bibliography list additional sources for further information.

Teen Pregnancy. The United States ranks highest among industrialized countries in teen pregnancy rates. U.S. rates are double those in England, Wales, France, and Canada; three times higher than in Sweden; and seven times higher than in the Netherlands.⁵⁴ Gradual decline in adolescent pregnancies and childbearing in the 1970s and 1980s are attributed to increased access to contraceptives and abortion services. However, teen pregnancy rates have increased again in the past four years.

More than one million teenagers, ages 15 to 19, become pregnant each year.⁵⁵ This figure represents about one in nine young women and about one in five of those who are sexually active. Six million children under age five live with mothers who were adolescents when they gave birth; and 1.3 million children currently live with teenage mothers.⁵⁶ The National Research Council estimates that 30 percent of teenagers who give birth will become pregnant again within two years.⁵⁷

The average American male becomes sexually active at 15.7 years of age, while the average for females is 16.2 years old. Only one in five sexually active females uses a contraceptive method.⁵⁸ Fifty percent of sexually active teens did not use contraception during their first sexual encounter, and 15 percent have never used contraception. More than 20 percent of first pregnancies occur within a month of first intercourse, and one-half occur within six weeks.⁵⁹

Services associated with teen births cost federal, state, and local governments billions of dollars each year. Related services include medical assistance, welfare, food assistance, public housing, child protective services, and foster care. American taxpayers paid over \$25 billion in 1990 for social, health, and welfare services to families begun by teenage mothers.⁶⁰

The Southern Regional Project on Infant Mortality reports that among its 17 member states, costs associated with supporting families begun by an adolescent mother totaled over \$5.7 billion in FY

1991. Costs included \$2.2 billion for Aid to Families with Dependent Children, \$2 billion for Medicaid, and \$1.5 billion for food stamps. The cost figures do not include expenditures for other public programs such as remedial education, job training, day care, housing subsidies, WIC, subsidized school meals, special education, and foster care.⁶¹ In contrast, only \$110 million in government funds were invested for adolescent pregnancy prevention efforts in the 17-state southern region in FY 1992.⁶²

Both mothers and infants run significantly higher health risks when pregnancy occurs in adolescence. In 1989, only 54 percent of teen mothers who gave birth received prenatal care in the first trimester, and 14 percent received late or no prenatal care. Many pregnant teens either do not realize they are pregnant or deny the possibility. In the meantime, pregnant teens may continue to engage in risky behaviors such as drinking, smoking, and using other drugs, and most are not aware of the nutritional needs related to pregnancy. Teenagers have a higher incidence of maternity-related complications, including premature birth, anemia, pregnancy-induced hypertension, cervical trauma, and toxemia.⁶³

Parenting responsibilities and low education levels often limit opportunities for financial independence by teen mothers. Approximately 80 percent of young mothers drop out of high school, at least for awhile, and only 56 percent ever finish.⁶⁴

STATE APPROACHES

States address adolescent health care needs through a number of initiatives. About 33 state health departments have adolescent coordinators. New Jersey funds school-linked adolescent services. Georgia uses federal block grant funds to help fund local programs for adolescents, and states tackle the teen pregnancy issue in a variety of ways, as illustrated by Maryland's multifaceted approach. In addition, adolescents also benefit from programs and services described in other sections, such as "Insurance" and "Medicaid."

SCHOOL-LINKED SERVICES

Program Highlight. New Jersey's School Based Youth Services Program (SBYSP) supports 29 local efforts that provide health, employment, and social services in or near public secondary schools. The comprehensive "one-stop shopping" model provides

needed services in a convenient location for students who otherwise may not receive them. The program intends to decrease high school dropout rates, improve students' health and mental health status, assist students with life skills or additional education for employment, and teach parenting skills for students who need them.

Legislation. Initiated by the Department of Human Services in 1988, the legislature appropriates funds for the program, totaling \$6.8 million for FY 1993.

Eligibility. The state-level SBYSP targets youth ages 13 to 19 and provides assistance to 29 local projects, at least one per county. The SBYSP gives priority to areas with extensive teen problems, such as poverty, substance abuse, high dropout rates, unemployment, pregnancy and health problems, abuse or neglect, court involvement, mental illness, and suicide. Local programs apply for state assistance and must include a school district and one or more community nonprofit or public agencies.

Administration. The Department of Human Services administers the School Based Youth Services Program at the state level. Program strategists preferred to house the program in the human services agency instead of the education agency to help protect it in times of education budget cuts. Local public or nonprofit entities and schools manage the local programs, with a project director at each site. Project directors and state-level program staff meet monthly to discuss problems and progress. Local programs usually include a nurse or part-time physician, a mental health counselor, a substance abuse counselor, an employment specialist, and a human services coordinator.

Implementation. After recognizing the need for more comprehensive services for adolescents, the Department of Human Services initiated the School Based Youth Services Program in 1988. The program now provides individual services to approximately 14,000 students and recreation and group activities to several thousand more students. In the past two years, two sites expanded to serve students in kindergarten through eighth grade.

Services. The state-level SBYSP surveyed students about needed services and encouraged local programs to do likewise. Located in or near secondary schools, local programs funded by the SBYSP provide a broad range of services, including primary and preventive health services; drug and alcohol abuse counseling; family crisis counseling; nutrition counseling; employment counseling, training, and placement; summer and part-time job

development; child care; and referrals to other health and social service providers. Although local programs may provide family planning services, state funds may not pay for contraceptives or abortion services. Local programs offer services during and after school, on weekends, and in summer. All programs provide recreation services and many have a drop-in center.

Funding. The School Based Youth Services Program has its own line item in the Department of Human Services' budget, and the legislature appropriated \$6.8 million in FY 1993 to fund the program. The state program allocates funds to 29 different sites under negotiated contracts. Local programs must contribute a 25 percent match, either through direct financial participation or in-kind services. The Department of Human Services would like to certify schools as Medicaid providers to capture a federal match for reimbursable services given to Medicaid-eligible youth.

Evaluation. State-level program staff monitor local SBYSP sites through technical assistance activities around the state. The state also gathers data about types and amounts of services, numbers of students served, problems with the services, and other pertinent information. In 1991, the Kennedy School of Government at Harvard University named the New Jersey program one of the 10 best for replication after judging it and 1,500 other applicants.

Program Limitations or Concerns. Some persons express concern that schools may not be able to provide the comprehensive services youth require or the continuity of care that a year-round "medical home" provides. Others argue that schools should concentrate on the business of education and not social and health services.

Contact: New Jersey School Based Youth Services Program, New Jersey Department of Human Services, CN 700, 222 South Warren Street, Trenton, New Jersey 08625; (609) 292-7816.

Similar Initiatives. Although many school districts around the country employ nurses, most have ratios of one nurse to hundreds or even thousands of children. Also, most such school programs do not provide the more comprehensive services referred to as "school-based" or "school-linked" services. In addition, many states with the more comprehensive school-linked health services programs have them in just a few locations and most of them are funded with grants from various sources, including the federal government, The Robert Wood Johnson

Foundation, The Annie E. Casey Foundation, or other sources. Few state government initiatives provide statewide comprehensive health services through school-based or school-linked centers. Brief descriptions of programs in *Arkansas, Delaware, Florida, Kentucky, and New Mexico* follow.

Arkansas. The Arkansas Department of Health sponsors 25 clinics in schools through its School Health Program. Clinic staff, mostly public health nurses and social workers, are Department of Health employees, although local school boards control programs and services offered by the clinics. Several sources fund the clinics, including Medicaid and other federal funds, a one-time grant from the state's Indigent Health Care Advisory Council, and a grant from the Johnson & Johnson Community Health Care Program. School districts apply for funding and may choose to offer any of the following services through their clinics: EPSDT screenings; treatment for minor illnesses or injuries; sports-related or general physicals; immunizations; tuberculosis skin tests; monitoring of chronic conditions; laboratory testing; wellness promotion, such as mental health counseling, nutrition education and counseling, and health education classes; screening for vision, hearing, scoliosis, high blood pressure, diabetes, and other health problems; dental screening and referral for care; reproductive health counseling and services, including contraception; safety and environmental consultation; health education training for teachers; and resource coordination.

Limited funds necessitate a competitive selection process for schools, based on criteria that include the proportion of students who receive free lunch; high rates of teen pregnancies, dropouts, suspensions and expulsions, and child abuse reports; and the level of community support (Ark. Code Ann. sec. 6-18-703). Contact: Arkansas Department of Health, Division of Child and Adolescent Health, 4815 West Markham Street, Little Rock, Arkansas 72205; (501) 661-2000.

Delaware. The Delaware General Assembly has funded school-based demonstration projects since 1986. Four wellness centers exist in state high schools, and two more will be added in the near future. In addition to state appropriations, the Maternal and Child Health Services Block Grant funds the programs. The state contracts with the Visiting Nurses Association to provide services at three of the centers, and the Division

of Public Health provides staff for the fourth. Services include health screenings; diagnosis and treatment of minor illnesses; screening and treatment of sexually transmitted diseases; counseling for personal problems, mental health, and nutrition; health education; and referral for acute and chronic illnesses. In 1992, almost one-third of the 8,204 student visits were for mental health counseling. Between 30 and 50 percent of center users are medically uninsured. Contact: Office of Adolescent Health, Health and Social Services Department, P.O. Box 637, Dover, Delaware 19903; (302) 739-4785.

Florida. The Florida Legislature expanded the state's School Health Services Program in 1990 by repealing the sales tax exemption on physical fitness club memberships. The 1990 legislation provided a funding source to assist schools that have a high incidence of medically underserved high-risk children and adolescents, teenage pregnancies, low birthweight babies, and infant mortality (Fla. Stat. Ann. sec. 402.321). Contact: Department of Education, 325 W. Gaines Street, Florida Education Center, Room 126, Tallahassee, Florida 32399-0400; (904) 487-8520.

Kentucky. The Kentucky Education Reform Act of 1990 ordered an interagency task force to design and implement a five-year plan establishing Family Resource and Youth Services Centers in or near schools where at least 20 percent of students qualify for free school meals. An estimated 1,000 schools qualify for such centers, to be phased in by June 1995, with 222 operating as of March 1993. Centers must address a core set of services, including child care; employment counseling, training, and development; and referral for medical, educational, social, mental health, and family support services. Services must be coordinated with existing community, regional, and state agencies (Ky. Rev. Stat. Ann. sec. 156.497). Contact: Family Resource/Youth Services Branch, 275 E. Main Street, Frankfort, Kentucky 40621; (502) 564-4986.

New Mexico. The state contracts with 13 local programs to provide school-based health services, using state appropriations and federal Maternal and Child Health Services Block Grant funds. A new collaborative project will use Medicaid funds to support school-based services. Thirteen additional school- or community-based programs provide services to

both prevent adolescent pregnancies and assist pregnant and parenting teens. Services include family life education and school-based day care programs, which provide parenting skills, child development information, and case management services.

New Mexico's school-based adolescent initiatives are one component of the state's maternal and child health services. The County Maternal and Child Health Plan Act of 1991 encourages the state to develop comprehensive, community-based MCH services to meet the needs of child-bearing women and their families and thereby improve the long-term health of New Mexicans. Counties may create MCH planning councils to develop a local MCH plan. Plans must include a needs assessment and resource inventory, and must specifically address adolescent health needs. Current services provided to adolescents under county MCH plans include clinical health services and health education, family counseling, violence prevention, mentoring, life planning skills, and an adolescent hotline (N.M. Stat. Ann. sec. 24-1B-1 et seq.). Contact: Maternal and Child Health Bureau, Department of Health, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, New Mexico 87502; (505) 827-2350.

ASSISTANCE TO LOCAL PROGRAMS

Program Highlight. Georgia's Comprehensive Adolescent Health Projects program uses federal Title V Maternal and Child Health Services Block Grant funds to support school-based and community-based programs in 17 counties around the state. The program assists local efforts to keep children and youth healthy and in school. The local programs foster coordination among schools, public health clinics, and mental health and substance abuse agencies. Health and human services personnel reach out to children and youth where they naturally congregate—local schools.

Legislation. The Georgia General Assembly specifically appropriates funds for one of the local projects, called Project DAISY, a multipurpose community teen clinic in Waycross, Georgia. State law mandates AIDS and sex education, but prohibits distribution of contraceptives on school property.

Eligibility. The Comprehensive Adolescent Health Projects program targets uninsured, underinsured, and Medicaid-eligible children and teens. Local

policies require parental permission for all services provided on school campuses but not for services provided in off-campus clinics and health departments.

Administration. The Office of Adolescent Health, Division of Public Health, Department of Human Resources, funds school-based and community-based health programs in 17 counties. The Office of Adolescent Health awards grants to local communities, based on needs and on the demonstrated collaboration of local public health, mental health, and school officials. The program currently assists health clinics in 14 high schools, 13 middle schools, eight elementary schools, and one community-based teen resource center.

Implementation. The earliest program began in 1985 in Waycross in response to rising teen pregnancy rates in the local high school. Others began in 1987 when federal Maternal and Child Health Services Block Grant funds became available. More than 12,000 youth were served in 1991, with almost 24,000 visits for services.

Services. Both school-based and community-based clinics funded under the Comprehensive Adolescent Health Projects program provide a range of health and social services. Although specific sites may cover different services, the most common include the following: primary care; first aid; physical exams; screenings for hearing, vision, anemia, sickle cell, and scoliosis; crisis intervention; mental health and peer counseling; immunizations; life skills and health education training; nutrition counseling; dental evaluations; diagnosis and treatment of sexually transmitted diseases; pregnancy testing; abstinence counseling; and referral to other services, such as family planning.

Because state law prohibits contraceptive services in schools, school-based clinics refer teens seeking contraception to community-based health clinics for family planning needs. Students needing mental health and substance abuse services may be referred to local mental health clinics. Others may be referred to social service agencies for needed services. To maintain continuity of care, many of the health professionals who provide services in schools also staff the community clinics. In addition, the clinics coordinate with local WIC programs, especially for pregnant teens, and with the Medicaid EPSDT program. Some participating schools also provide EPSDT screenings.

All projects provide year-round services, at least in the off-campus clinics. For example, one program

targets middle school students who have failed two or more subjects. The students work over the summer with a nurse, a counselor, and a teacher on health issues, responsibility, self-esteem, group dynamics, and academics.

Funding. Funds for the Comprehensive Adolescent Health Projects come from the federal Maternal and Child Health Services Block Grant (\$991,700 in 1992), from state funds (\$44,500 in 1992) for the Waycross DAISY project, and from private foundation grants for two of the school-based projects.

Evaluation. The Emory University School of Public Health assists the Office of Adolescent Health and individual project sites with evaluations. Teen pregnancies in the Waycross DAISY project declined more than 50 percent, and the pregnant teen dropout rate plummeted to zero.

Program Limitations or Concerns. Funding continues to be the primary concern, because limited funds restrict program expansion to other areas that could use assistance.

Contact: Office of Adolescent Health, Georgia Department of Human Resources, Division of Public Health, Room 201, 878 Peachtree St., N.E., Atlanta, Georgia 30309; (404) 894-7505.

ADOLESCENT PREGNANCY PREVENTION

Program Highlight. The Maryland Governor's Council on Adolescent Pregnancy promotes teen pregnancy reduction through several strategies. Recognizing that adolescents are not a homogeneous population, the council sponsors the following:

- Campaign for Our Children (CFOC), a five-year media campaign using television, radio, posters, billboards, and educational materials to promote a delay of sexual activity among pre-adolescents and adolescents;
- Family planning services at locations and times accessible to sexually active teens at little or no cost, including aggressive outreach to advise teens of available services, service locations, and follow-up to contraceptive dispensation;
- Parents and Children Talking (PACT!), a program designed to provide parents with communication skills to assist them in their

roles as the primary sexuality educators of their children; and

- Community Incentive Grants to encourage local efforts in adolescent pregnancy prevention.

Legislation. The Maryland General Assembly established the Governor's Council on Adolescent Pregnancy in 1986. The law requires the council to develop, coordinate, and evaluate programs and policies for reducing teen pregnancy and to promote positive outcomes for pregnant and parenting teens and their children by combining public and private efforts (Md. Fam. Law Code Ann. sec. 15-101 et seq.).

Eligibility. The council's strategies target every teen in the state. Teen pregnancy prevention messages are on posters, billboards, and television; and council-sponsored materials are used in schools' sexuality curricula.

Administration. The council includes cabinet secretaries; members of the general assembly; and representatives from the community, academia, local government, and the private sector. The council serves as coordinator among department and agency directors, legislators, and business people. The Department of Health and Mental Hygiene, Division of Family Health Services, administers family planning services and teen clinics.

Implementation. The newly formed council surveyed local health department family planning clinics and other sources for information about teen pregnancy and existing programs in Maryland. Council members learned that family planning services were not readily accessible to teenagers and recommended that the general assembly increase funding for such services by \$2 million. New funds were used to establish teen clinics in three areas with the highest rates of teen pregnancy. In addition, one of the council's first activities was to initiate the media campaign to delay the onset of adolescent sexual activities.

Services. As described under "Program Highlight," the council sponsors numerous activities that involve adolescents, parents, and communities. In addition to the media campaign and community grants, the state provides a variety of services through family planning clinics, school-based health clinics, teen clinics, and local community programs. Services include dispensing contraceptives; counseling for drug and alcohol abuse, sexually transmitted diseases, and nutrition needs; teaching

health education; and providing referrals for other services. Many communities sponsor services in convenient locations, such as shopping malls, and at convenient times, such as evenings and weekends.

Maryland also sponsors "Three For Free," a condom distribution program to help prevent teen pregnancy. The program distributes over three million condoms annually throughout the state in 460 sites, targeting individuals at high risk of pregnancy, sexually transmitted diseases, and human immunodeficiency virus (HIV) infection.

Funding. In response to the council's findings and recommendations, the general assembly increased funding to expand family planning services to teens by \$2 million annually. The legislature also provides \$250,000 per year to award Community Incentive Grants for local teen pregnancy prevention programs.

Campaign for Our Children, the media campaign to delay sexual activity among teens, started in 1988 with \$100,000 from the Department of Health and Mental Hygiene's budget. Later contributions from the Department of Human Resources brought the state's annual share to \$320,000. An additional \$3.5 million over five years has been raised from the business community to support the campaign, making it a public-private partnership. The president of a prominent public relations and advertising firm serves as the unpaid executive director of the campaign. His firm develops creative materials, with advice from the Governor's Council on Adolescent Pregnancy.

Evaluation. While births to teens continued to rise in most states, births to Maryland teens under age 18 decreased 13.2 percent between 1988 and 1990, meaning 441 fewer babies were born to teens. During the same time period, 589 fewer abortions were received by teens, representing a 23.3 percent decline. Baltimore City, an area with a high teen pregnancy rate, experienced a 10.2 percent decline in teen births and a 43.4 percent reduction in abortions during the same period.

Program Limitations or Concerns. Program staff report no limitations or concerns about Maryland's efforts to reduce teen pregnancies. Although providing contraceptives to teens is a controversial issue in many places around the country, Maryland officials report that their multidimensional approach is successful. The state promotes a delay in sexual initiation, encourages parents to become the primary sexuality educators of their children, encourages strong community coalitions, and provides family planning services to sexually active teens.

Contact: Governor's Council on Adolescent Pregnancy, 300 West Lexington Street, Box 11, Baltimore, Maryland 21201; (410) 333-0270.

Similar Initiatives. Policymakers in all states face the issue of unplanned adolescent pregnancies. Some states sponsor fairly comprehensive efforts to reduce the problem, while others struggle with the difficult public policy issues involved with teen sex. This section highlights programs in *California* and *Oklahoma*.

California. In an effort to curb the increasing rate of teen pregnancies in California, Governor Pete Wilson designated \$20 million for a prevention initiative. The initiative, begun in July 1991, aims to postpone sexual activity among youth ages 12 through 14, link sexually active adolescents with family planning resources, and prevent immediate repeat pregnancies among adolescent parents.

Under the governor's initiative, the California Office of Family Planning (OFP) sponsors the Education Now and Babies Later (ENABL) program. The ENABL campaign, which targets 12- to 14-year-olds, awards competitive contracts totaling \$5 million to schools and community organizations to implement the "Postponing Sexual Involvement" curriculum, a program developed at Emory University in Atlanta. As part of the initiative, the OFP funds a statewide media campaign to promote the ENABL program. Program administrators hope to reach more than 200,000 teens throughout the 30 counties with the highest adolescent pregnancy rates.

For sexually active teens, the governor's initiative earmarked \$13 million to expand family planning clinical services and add new counseling services and outreach. The outreach campaign uses radio and television media to advertise the toll-free hotline number for low-cost family planning services. The program encourages teens who are sexually active to use contraception through outreach and counseling to reduce barriers to effective contraceptive use. The initiative expands and makes more "teen sensitive" services in family planning clinics, primary care clinics, city and county health agencies, and university-affiliated clinics.

Participating clinics offer more than contraceptive services. All provide complete physical exams, including screening for sexually transmitted diseases, anemia, and

breast and cervical cancer; pregnancy tests; treatment for sexually transmitted diseases; and counseling. Some also provide infertility services, sterilization, or counseling about and testing for HIV infection. Approximately 500 clinics serve the estimated 500,000 annual clients. For many clients, the clinics are their sole source of health care. Contact: Office of Family Planning, Department of Health Services, 714 P Street, Room 398, Sacramento, California 95814; (916) 654-0357.

The governor's three-year initiative also added \$2 million for the Adolescent Family Life Program (AFLP). The AFLP links pregnant and parenting teens ages 17 and under to case managers who help them stay in school, obtain needed health services for themselves and their babies, prevent immediate repeat pregnancies, and seek job training opportunities and placement. The AFLP currently serves approximately 6,500 clients annually, at an average cost of \$1,375 per client. The legislature gave the Adolescent Family Life Program, begun as a pilot program in 1985, statutory authority in 1988 (Cal. Health and Safety Code sec. 309.100 et seq.). The program's \$7.2 million budget comes from Title V Maternal and Child Health Services Block Grant funds. Contact: Maternal and Child Health Branch, Department of Health Services, 714 P Street, Room 750, Sacramento, California 95814; (916) 657-1332.

Oklahoma. The Oklahoma Legislature appropriated \$250,000 in FY 1992 for distribution to community Teen Pregnancy Prevention Projects. Projects must have community support, a community task force, educational components, and public awareness activities. Eleven projects were funded in 1992, ranging from \$16,500 to \$24,000. Programs involve a variety of activities, including public awareness campaigns, academic tutoring, self-esteem curriculum, teen parent speakers' bureaus, school-based presentations, adolescent conferences, support groups for teen mothers, home visitation for pregnant and parenting teens, and peer counseling. A description of one of the more unique community efforts follows.

Community Health Centers, Inc., Special Projects, Mary Mahoney Memorial Health Center in Oklahoma City sponsors the Young Black Men's Forum. This teen pregnancy prevention program, modeled after a similar one in San Francisco, focuses on African

American males ages 10 to 19. Groups of 25, divided by age, meet twice weekly for 46 weeks. Males serve as mentors for the groups in an effort to instill a sense of personal responsibility, improved decision-making skills, pride, identity, respect for the opposite

sex, and behavioral changes that support pregnancy prevention. Contact: Teen Pregnancy Prevention Projects, Department of Health, 1000 N.E. Tenth, Oklahoma City, Oklahoma 73117-1299; (405) 271-4476.

Other Strategic Issues

This publication cannot address adequately the many additional issues related to improving children's health, such as health promotion and disease prevention campaigns, injury prevention efforts, oral health initiatives, programs related to specific problems such as lead poisoning or individual diseases, and health care provider issues. This section briefly highlights a few other important issues of concern to state policymakers, including access to care for minority populations, early intervention programs for high-risk families, and emergency medical services. Ideally, health care reform initiatives address the full range of issues related to children's health and well-being.

MINORITY HEALTH

As referenced previously in this publication, members of minority groups are overrepresented in the uninsured population and among children who lack the full series of immunizations or access to other primary care services. Many minorities also are at higher risk of health care problems such as heart disease, cancer, and diabetes. Many of the more serious problems stem from inadequate screening and primary care services. Some members of minority groups also face language and cultural barriers. Ohio and a number of other states address minority health care issues through special minority health commissions or offices. A brief description of Ohio's Commission on Minority Health follows.

Program Highlight. Ohio's Commission on Minority Health promotes health for members of minority groups in the state. The commission funds culturally specific, nontraditional community demonstration projects to meet the needs of African Americans, Hispanics, Asian Americans, Native Americans, and other minorities of all ages.

Legislation. The Ohio General Assembly created the Commission on Minority Health in 1987 after the Governor's Task Force on Black and Minority Health documented major health problems in minority populations (Ohio Rev. Code 3701.78).

Eligibility. The commission's activities promote health for members of all minority groups in Ohio. The commission funds community-based programs that may focus on particular populations or health-related conditions, such as prenatal care in a predominantly Hispanic community, or

neighborhood screening for hypertension, cholesterol, and diabetes among adult African Americans.

Administration. Eighteen members serve on the Ohio Commission on Minority Health, including legislators; health professionals; the superintendent of public instruction; and the directors of the departments of Health, Mental Health, Mental Retardation and Developmental Disabilities, and Human Services. A director and staff serve the commission and carry out its duties.

Implementation. The Governor's Task Force on Black and Minority Health was created in 1986 to define minority health problems in Ohio and recommend solutions. In response to the task force's findings, the legislature created the Ohio Commission on Minority Health in 1987. The commission solicited applications from community-based programs and funded 17 local programs in FY 1988. The commission continues to fund local programs, and it initiated Minority Health Month as an annual effort to promote public awareness about health issues of particular concern in minority communities.

Services. The commission sponsors a variety of activities to promote minority health issues in the state, including Minority Health Month, public forums, a quarterly newsletter, minority recruitment into health professions, and grants to community-based programs. Minority Health Month has grown from 88 events sponsored around the state in 1989 to more than 300 events in 1992. Events range from health screenings and educational seminars to dance performances and fitness fairs. Children and youth become involved in pediatric screening clinics, poster contests, rap contests, workshops, and food festivals.

The commission has funded more than 50 community-based programs since its creation. Most programs serve a variety of clients, and some specifically target children and youth. For example, several programs provide services to at-risk adolescents, including health education, drug abuse treatment or prevention, and teen pregnancy prevention. One program seeks to reduce pesticide poisoning among migrant farm workers, including children. Another program conducts outreach to African American females between ages 11 and 24 to address well-child care, nutritional needs, parenting support and education, and family

planning. Several programs target at-risk young males and promote health and healthy lifestyles, self-esteem, peer-to-peer communication, self-understanding, and disease and violence prevention.

Funding. The legislature appropriates funds for commission activities and grants for local community projects, amounting to \$6 million in FY 1992. In addition, the commission receives grants from other sources, including the federal government. In 1991, the Maternal and Child Health Bureau funded two projects: a three-year health project for Southeast Asian mothers and their children, and a three-year violence prevention project in African American neighborhoods. Communities, health organizations, and businesses contribute money and other resources to support Minority Health Month activities.

Evaluation. Commission supporters credit it with raising awareness about minorities' health status and sponsoring and promoting activities to improve the health status of minorities through education and services. Thousands of persons have received health screenings, services, and education through commission activities. Projects funded by the commission report their activities and accomplishments. The commission has assisted several other states that established similar minority health commissions or offices.

Program Limitations or Concerns. As with all similar programs, finite resources limit the amount of activities the commission can sponsor and the number of community-based projects it can fund.

Contact: Ohio Commission on Minority Health, 77 South High Street, Suite 745, Columbus, Ohio 43266-0377; (614) 466-4000.

EARLY INTERVENTION FOR HIGH-RISK FAMILIES

Many state and federal programs have been created to serve particular needs, such as medical problems, lack of food or shelter, and child abuse. Services often exist in separate departments and agencies without much communication among them. Many persons in need of assistance do not receive services until a crisis arises, when more resources must be devoted to solving the problem than would have been required to prevent it. *Hawaii* works to prevent or reduce the extent of future problems through early screening and intervention services.

Program Highlight. Hawaii's Healthy Start Program serves at-risk families with children from birth through age five. Nearly 50 percent of the state's newborns are screened for risk factors. Trained paraprofessionals provide a variety of support services to families who meet certain risk criteria.⁶⁵

Legislation. The Hawaii Legislature first funded the Healthy Start Program on a pilot basis in 1984. The enabling legislation concerned promoting positive child development among high-risk families and preventing child abuse (Hawaii Rev. Stat. sec. 321-36 et seq.).

Eligibility. The program targets families with newborns who meet certain risk criteria developed by the Kempe National Center for Prevention and Treatment of Child Abuse. Program personnel screen approximately 50 percent of the state's families with newborns. About 20 percent of families screened are determined to be at risk for a variety of problems, such as child abuse, lack of access to health care, or inadequate housing or nutrition. Program personnel invite families determined to be "at risk" to participate in the Healthy Start Home Visiting Program.

Administration. The state's Division of Maternal and Child Health administers the Healthy Start Program. In collaboration with seven community-based private social services agencies, Hawaii's Family Stress Center provides staff training and technical assistance. Trained paraprofessionals work with 15 to 25 families each.

Implementation. The Healthy Start concept began as a demonstration program on child abuse prevention with a federal Maternal and Child Health Bureau grant in the early 1970s. MCH funding and other federal assistance helped establish the Hawaii Family Stress Center. The center operated a demonstration home visitation program for child abuse prevention. It also researched and advocated new approaches to serve high-risk families with infants and toddlers. As federal funding dwindled, center directors sought and received assistance from the legislature in 1984; the initiative then became "Healthy Start." The program expanded to encompass a variety of services for at-risk families, including connecting them with a "medical home" for health services.

Services. Trained paraprofessionals visit families at home, initially on a weekly basis. In addition to serving as role models for parents, home visitors provide emotional support, 24-hour crisis

intervention services, and developmental screenings. They also link families to services such as medical care, food assistance, subsidized housing, and parent support groups. Most Healthy Start locations offer a place for groups to meet, and many offer recreation rooms or toy lending "libraries."

Funding. The legislature appropriated \$400,000 in 1984 to support the Healthy Start Program. The appropriation grew to \$7 million for the 1990-91 biennium. Policymakers would like to secure Medicaid funding to expand the program.

Evaluation. Of the first 1,200 families served by the Healthy Start Program, fewer than 1 percent became involved with the child welfare system. According to program personnel, up to 20 percent of the families would be expected to be involved with child abuse or neglect investigations without early intervention services. Health department staff report that the reduced need for foster care saves the state substantial money. A formal evaluation of the program is under way.

Program Limitations or Concerns. Retaining skilled home visitors remains a challenge. Program personnel also would like to reduce the refusal rate; approximately 20 percent of families invited decline to participate in the program. About 20 percent of participating families need multiple professional service interventions, such as mental health, substance abuse treatment, violence counseling, assistance with chronic or disabling conditions, or decent housing. Healthy Start must rely on other programs to provide many of the needed services.

Contact: Healthy Start, Division of Maternal and Child Health, Department of Health, 741-A Sunset Avenue, Honolulu, Hawaii 96816; (808) 733-9024.

EMERGENCY MEDICAL SERVICES FOR CHILDREN

Injuries remain the major cause of death among young Americans, killing more children and youth ages one to 18 than all other causes.⁶⁶ The majority of infants, children, and young adults who might benefit from pediatric critical care services do not receive them.⁶⁷ Children have some unique needs when it comes to emergency medical services. For example, lifesaving equipment that works for an adult may be inappropriate for a small child. Children sometimes exhibit different symptoms than adults, and untrained medical personnel may make fatal judgments when treating children based on

proper medical practices for adults. Many communities lack the facilities or personnel to deal adequately with severely ill or injured children. In 1992, New Jersey became the first state to establish a statutory program that specifically concerns children's emergency medical needs.

Program Highlight. The New Jersey Emergency Medical Services for Children (EMSC) program provides personnel training, equipment, and standards to improve services for children who need emergency care.

Legislation. Signed into law in September 1992, Senate Bill 408 created the Emergency Medical Services for Children program. The law defines duties of the EMSC program and also establishes an advisory council (N.J. Stat. Ann. sec. 26:2K).

Eligibility. The EMSC program intends to benefit all New Jersey children who need emergency medical services.

Administration. The EMSC program was established within the Office of Emergency Medical Services in the Department of Health. A coordinator manages the EMSC program, with advice from a 14-member advisory council. The council consists of a number of medical professionals and three members without a medical background, including two parents with children under age 18.

Services. The Emergency Medical Services for Children program must establish the following: education programs for emergency care professionals, guidelines for referring children to the appropriate emergency treatment facility, pediatric equipment guidelines for prehospital care, guidelines for hospital-based emergency departments, guidelines for pediatric intensive care units and trauma centers, an interhospital transfer system for critically ill or injured children, and pediatric rehabilitation units.

Funding. A federal grant of \$500,000 from the U.S. Department of Health and Human Services enabled New Jersey to create its EMSC program.

Evaluation. The program is too new for any evaluation information.

Program Limitations or Concerns. Unknown; the program is just beginning.

Contact: Emergency Medical Services for Children, Department of Health, John Fitch Plaza, CN 360, Trenton, New Jersey 08625; (609) 292-7837.

Healthy Kids!

Conclusion

All states sponsor programs designed to improve children's health. This publication describes a variety of approaches to the common goal. Some initiatives provide financing mechanisms, such as Medicaid or state-subsidized insurance. Other programs focus on particular populations, such as children with special health care needs, high-risk adolescents, or minorities. Still other approaches enable children to receive certain services, such as immunizations or screenings for particular illnesses or conditions.

Concern exists, however, about fragmented efforts that address certain health needs of children without providing continuity of care, coordination among services and service providers, and public outreach and education efforts to ensure appropriate care. For example, public efforts to immunize preschool children may not address their needs for more comprehensive well-child screenings and services. Screening children for treatable conditions may not be followed by appropriate treatment for the problems found. Expanding Medicaid eligibility or creating an insurance program does not guarantee

access to care for the intended populations. Many persons do not realize they may be eligible for assistance or do not understand what services should be received and when. Others face a variety of barriers, such as difficult application procedures, a shortage of providers willing to see them, lack of transportation, or language and cultural differences. In addition, traditional medical services provided without recognition of other needs, such as food, shelter, and a safe environment, do not adequately address the health and well-being of children.

Ideally, as called for in the federal *Healthy Children 2000* objectives, all children should have a "medical home" to address their full range of primary and preventive health care needs. Linkages should exist to other health and social services to help ensure a child's well-being.

As the health care reform debate intensifies at the federal level, states continue their efforts to improve access to quality health care services for children and others who need them. This publication intends to help states in those efforts.

Appendix: RESOURCES FOR FURTHER INFORMATION

GENERAL RESOURCES

American Academy of Pediatrics
Division of Government Affairs
141 Northwest Point Boulevard
P.O. Box 927
Elk Grove Village, Illinois 60009
(708) 228-5005

Association of Maternal and Child Health Programs
1350 Connecticut Avenue NW, Suite 803
Washington, D.C. 20036
(202) 775-0436

Association of State and Territorial Health Officers
415 Second Street NE, Suite 200
Washington, D.C. 20002
(202) 546-5400

Center on Budget and Policy Priorities
777 N. Capitol Street NE, Suite 705
Washington, D.C. 20002
(202) 408-1080

Children's Defense Fund
25 E Street NW
Washington, D.C. 20001
(202) 628-8787

CityMatCH
University of Nebraska Medical Center
Department of Pediatrics
600 South 42nd Street
Omaha, Nebraska 68198-2165
(402) 559-8323

Healthy Mothers, Healthy Babies Coalition
409 12th Street SW
Washington, D.C. 20024-2188
(202) 863-2458

National Health/Education Consortium
Institute for Educational Leadership
1001 Connecticut Avenue NW
Suite 310
Washington, D.C. 20036
(202) 822-8405

Maternal and Child Health Bureau
Parklawn Building, Room 18A-30
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2250

National Association of County Health Officials
440 First Street NW, Suite 500
Washington, D.C. 20001
(202) 783-5550

National Center for Education in Maternal and Child Health
2000 15th Street North, Suite 701
Arlington, Virginia 22201-2617
(703) 524-7802

National Center For Policy Coordination in Maternal and Child Health
Institute for Child Health Policy
5700 Southwest 34th Street, Suite 323
Gainesville, Florida 32608
(904) 392-5904

National Commission to Prevent Infant Mortality
Switzer Building, Room 2014
330 C Street SW
Washington, D.C. 20201
(202) 205-8364

National Conference of State Legislatures
Maternal and Child Health Project
1560 Broadway, Suite 700
Denver, Colorado 80202-5140
(303) 830-2200

National Governors' Association
Center for Policy Research
444 North Capitol Street NW Suite 250
Washington, D.C. 20001-1512
(202) 624-5300

National Maternal and Child Health Clearinghouse
8201 Greensboro Drive, Suite 600
McLean, Virginia 22102
(703) 821-8955

Southern Regional Project on Infant Mortality
444 North Capitol Street NW
Suite 240
Washington, D.C. 20001
(202) 624-5897

The Southern Institute on Children and Families
2725 Devine Street
Columbia, South Carolina 29205
(803) 779-2607

Washington Business
Group on Health
777 North Capitol Street
Suite 800
Washington, D.C. 20002
(202) 408-9320

MEDICAID

American Public Welfare Association
810 First Street NE, Suite 500
Washington, D.C. 20002-4267
(202) 682-0100

Medicaid Bureau
Health Care Financing Administration
Room 233, East High Rise
6325 Security Boulevard
Baltimore, Maryland 21207-5187
(410) 966-7172

Federal Regional Medicaid Resources

Region I: (617) 565-1223 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Region II: (212) 264-2504 (New Jersey, New York, Puerto Rico, and the Virgin Islands)

Region III: (215) 596-1378 (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia)

Region IV: (404) 331-2418 (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee)

Region V: (312) 886-5354 (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Region VI: (214) 767-6493 (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Region VII: (816) 426-5925 (Iowa, Kansas, Missouri, and Nebraska)

Region VIII: (303) 844-2121, ext. 352 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming)

Region IX: (415) 744-3568 (Arizona, California, Hawaii, Nevada, American Samoa, Guam, and the Commonwealth of the Northern Marianas)

Region X: (206) 553-7807 (Alaska, Idaho, Oregon, and Washington)

IMMUNIZATION

American Academy of Pediatrics
(see listing under "General")

Centers for Disease Control and Prevention
Division of Immunization
1600 Clifton Road NE
Mail Stop E-05
Atlanta, Georgia 30333
(404) 639-1880

National Vaccine Injury Compensation Program
Health Resources and Services Administration
6001 Montrose Road, Room 702
Rockville, Maryland 20852
(301) 443-6593

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Family Voices
Box 769
Algodones, New Mexico 87001
(505) 867-3159

Human Services Research Institute
2336 Massachusetts Avenue
Cambridge, Massachusetts 02140
(617) 876-0426

Maternal and Child Health Bureau
Services for Children with Special Health Needs Division
Parklawn Building, Room 18A-27
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2350

New England SERVE
101 Tremont Street, Suite 812
Boston, Massachusetts 02108
(617) 574-9493

United Cerebral Palsy Associations, Inc.
1522 K Street NW, Suite 1112
Washington, D.C. 20005
(202) 842-1266

MINORITY HEALTH

Healthy Mothers, Healthy Babies
Committee on Minority Health
(see listing under "General")

Indian Health Service
5600 Fishers Lane, Room 6-05
Rockville, Maryland 20857
(301) 443-1083

Joint Center for Political and Economic Studies
1090 Vermont Avenue NW
Suite 1100
Washington, D.C. 20005
(202) 789-3500

National Black Women's
Health Project
1237 R. D. Abernathy Boulevard SW
Atlanta, Georgia 30310
(404) 758-9590

National Consortium For African American Children
c/o National Commission to Prevent Infant Mortality
(see listing under "General")

National Coalition of Hispanic Health and Human
Services Organizations (COSSMHO)
1030 15th Street NW, 10th Floor
Washington, D.C. 20005
(202) 371-2100

National Council of La Raza
810 First Street NE, Suite 300
Washington, D.C. 20002
(202) 289-1380

Office of Minority Health
Public Health Service
5515 Security Lane
Room 1102
Rockville, Maryland 20852
(301) 443-5084

ADOLESCENT HEALTH

The Alan Guttmacher Institute
111 Fifth Avenue
New York, New York 10003
(212) 254-5656

Center for Population Options
1012 14th Street NW
Suite 1200
Washington, D.C. 20005
(202) 347-5700

Maternal and Child Health Bureau
Child/Adolescent Primary Care Services Branch
Parklawn Building, Room 18A-39
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-4026

Southern Center on Adolescent Pregnancy Prevention
444 North Capitol Street, NW Suite 240
Washington, D.C. 20001
(202) 624-5897

Teenage Health Teaching Modules
Educational Development Center
55 Chapel Street
Newton, Massachusetts 02160
1 (800) 225-4276
(Promotes responsible decision making)

Notes

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22. U.S. Department of Health & Human Services, *Healthy Children 2000*, pp. 215-216.
23. U.S. Department of Health and Human Services, Health Care Financing Administration, *State Medicaid Manual, Part 5 — Early and Periodic Screening, Diagnosis, and Treatment*, HCFA-pub. 45-5 (Washington, D.C., September 1992).
24. Sarah Shuptrine et al., *Uninsured Children in the South* (Columbia, S.C.: The Southern Institute on Children and Families, November 1992), p. 28.
25. *Ibid.*, p. 27.
26. "State Coverage of Pregnant Women and Children - July 1992," *MCH Update*, National Governors' Association, pp. 5-8.
27. U.S. Department of Health and Human Services and the U.S. Department of Agriculture, *Model Application Form*. For further information, contact the Maternal and Child Health Bureau at (301) 443-2250.
28. For more information, contact the Association of Maternal and Child Health Programs at (202) 775-0436.
29. The National Commission to Prevent Infant Mortality, *One-Stop Shopping: The Road to Healthy Mothers and Children* (Washington, D.C., April 1991), p. 17.
30. For more information on one-stop shopping, contact the National Commission to Prevent Infant Mortality, the Association of Maternal and Child Health Programs, and the Center on Budget and Policy Priorities, all of which are listed in the appendix. The bibliography also lists related publications.
31. Mark J. Schlesinger and Leon Eisenberg, eds., *Children in a Changing Health System* (Baltimore, Md.: The Johns Hopkins University Press, 1990), p. 28.
32. U.S. Department of Health and Human Services, *Healthy Children 2000*, pp. 138-156.
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35. Barbara Wright and Martha P. King, *Americans with Developmental Disabilities: Policy Directions for the States* (Denver, Colo.: National Conference of State Legislatures, February 1991), p. 3.
36. U.S. Department of Health and Human Services, *Healthy Children 2000*, p. 178.

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54. "Teenage Sexual and Reproductive Behavior," *Facts in Brief*, Nov. 1, 1992, The Alan Guttmacher Institute, p. 2.
55. *Ibid.*, p. 1.
56. Fred M. Hechinger, *Fateful Choices: Healthy Youth for the 21st Century* (New York, N.Y.: Carnegie Corporation of New York, 1992), pp. 76-79.
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58. "Teenage Sexual and Reproductive Behavior," p. 1.
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62. *Ibid.*, pp. 12-13.
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65. Much of the information for the Hawaii Healthy Start program description comes from a case study done by Theresa Eckrich Sommer and Megan Berryhill for the Child and Family Policy Center in January 1992. For further information, contact the center at 100 Court Avenue, Suite 312, Des Moines, Iowa 50309; (515) 280-9027.
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Glossary

AAP — American Academy of Pediatrics

AIDS — Acquired Immune Deficiency Syndrome

AFDC — Aid to Families with Dependent Children

Anticipatory guidance — Talking with parents and children about developments that may occur in children between health care screenings

BC/BS — Blue Cross and Blue Shield

CDC — The federal Centers for Disease Control and Prevention

DPT — Diphtheria, tetanus, pertussis (whooping cough) vaccine

EPSDT — The Early and Periodic Screening, Diagnostic, and Treatment program under Medicaid

ERISA — The federal Employee Retirement Income Security Act of 1974

FPL — Federal Poverty Level

FY — Fiscal year

GAO — U.S. General Accounting Office

HCFA — Health Care Financing Administration, U.S. Department of Health and Human Services

Hep B — Hepatitis B

Hib — Haemophilus influenzae type b (for meningitis) vaccine

HIV — Human Immunodeficiency Virus, which causes AIDS

HMO — Health maintenance organization

IDEA — Individuals with Developmental Disabilities Act

MCH — Maternal and Child Health

MMR — Measles, mumps, rubella (German measles) vaccine

OPV — Poliomyelitis (polio) vaccine

OBRA-89 — The federal Omnibus Budget Reconciliation Act of 1989

PKU — Phenylketonuria — a treatable metabolic disorder

Respite care — Nonprofessional care that provides a break for the primary caretakers

SSI — Supplemental Security Income

TEFRA — Tax Equity and Fiscal Responsibility Act of 1982

"Underinsured" — Usually refers to persons who cannot afford to pay for medical costs not covered by their insurance, such as deductibles, copayments, or services not covered by an insurance policy

WIC — The federal Special Supplemental Food Program for Women, Infants, and Children

Annotated Bibliography

Aguilera, Esther. *Hispanics and Health Insurance, Volume 1: Status*. Washington, D.C.: Labor Council for Latin American Advancement and National Council of La Raza, March 1992.

Addresses the health insurance status of Hispanic Americans in the context of socioeconomic factors, health status, and health needs. Data are reported in chart form for uninsured, privately insured, and publicly insured Hispanic populations (52 pages).

Annie E. Casey Foundation and the Center for the Study of Social Policy. *Kids Count Data Book: 1992*. Greenwich, Conn.: The Annie E. Casey Foundation and Washington, D.C.: Center for the Study of Social Policy, 1992.

Contains state data for family income and poverty levels, AFDC and food stamp benefits as a percentage of poverty, uninsured children, low birthweight and infant mortality, child deaths, teen violent deaths, births to single teens, juvenile custody, high school graduates, and single-parent families (148 pages).

Association of Maternal and Child Health Programs. Maternal and Child Health Policy Research Center. *A Review of National Health Care Reform Proposals from a Maternal and Child Health Framework*. Washington, D.C., September 1992.

Reviews five national health care reform proposals based on a framework developed by the Association of Maternal and Child Health Programs. The framework addresses essential components of health service delivery and financing systems needed to meet the needs of women, children, youth, and families (23 pages).

Brown, Sarah S., ed. *Including Children and Pregnant Women in Health Care Reform: Summary of Two Workshops*. Washington, D.C.: National Academy Press, 1992.

Summarizes two workshops convened to assess seven proposals for national health care reform in relation to 11 health care goals for children and pregnant women. Proposals include four congressional plans and also plans submitted by the American Academy of Pediatrics, the American Medical Association, and the Health Insurance Association of America.

Center for Population Options. *Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences*, 6th edition. Washington, D.C., 1992.

Discusses public costs associated with adolescent pregnancies. The document includes information about the federal government and selected states and cities, including Florida, Kansas, New Mexico, Ohio, Oregon, Vermont, Wyoming, Baltimore, and San Francisco (45 pages).

Employee Benefit Research Institute. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1992 Current Population Survey." *Special Report and Issue Brief*, no. 133. Washington, D.C., January 1993.

Reports in chart form health insurance data from the March 1992 Current Population Survey, including the number of uninsured in each state and uninsured persons by employment status and type of industry, income level, age, family type, education level, race, and gender. The report briefly highlights key issues for each topic (70 pages).

The Future of Children. Journal published by the Center for the Future of Children, Los Altos, Calif.

"Drug-Exposed Infants" 1 (Spring 1991). This theme journal addresses the issues of maternal drug abuse and drug-exposed infants from several perspectives, including medical, social, judicial, legislative, child welfare, ethical, and economic viewpoints (120 pages).

"School-linked Services" 2 (Spring 1992). This issue is devoted to articles about the role of schools in providing or coordinating health and social services to children and their families (144 pages).

"U.S. Health Care for Children" 2 (Winter 1992). Articles in this issue discuss how health services are delivered to children, youth, and pregnant women; how the services are financed; and deficiencies that exist in meeting the needs of the populations. It also presents recommendations for policies to make the U.S. health care system more responsive to the needs of children and pregnant women (191 pages).

Hechinger, Fred M. *Fateful Choices: Healthy Youth for the 21st Century*. New York, N.Y.: Carnegie Council on Adolescent Development/Carnegie Corporation of New York, 1992.

Covers several adolescent issues, including teen pregnancy, drugs, alcohol, cigarettes, death, violence, and nutrition. It also offers policymakers recommendations for improving the quality of life for adolescents (255 pages).

Hill, Ian T.; and Breyel, Janine M. *Caring for Kids*. Washington, D.C.: National Governors' Association, 1991.

Describes a variety of ways for states to improve their Medicaid programs for children, including enrolling more eligible children, recruiting and retaining health care providers, and improving and coordinating services (80 pages).

Igoe, Judith B., and Giordano, Beverly P. *Expanding School Health Services to Serve Families in the 21st Century*. Washington, D.C.: American Nurses Publishing, 1992.

Describes proposals by the American Nurses Association to transform traditional school health programs into community-based family health centers, with ties to health care delivery systems in communities (52 pages).

Klerman, Lorraine V. *Alive and Well? A Research and Policy Review of Health Programs for Poor Young Children*. New York, N.Y.: National Center for Children in Poverty, Columbia University School of Public Health, 1991.

Describes health problems among children in poverty, the causes of the problems, and possible strategies for policymakers to address them (120 pages).

Liu, Joseph Tiang-Yau, and Sara Rosenbaum. *Medicaid and Childhood Immunizations: A National Study*. Washington, D.C.: Children's Defense Fund, January 1992.

Provides background information about childhood immunizations, addresses both the role of Medicaid and its problems related to providing vaccines, and makes recommendations to improve immunizations under Medicaid (35 pages).

Liu, Joseph Tiang-Yau; Regan, Carol; Orloff, Tracey M.; and Rivera, Lourdes A. *The Health of America's Children 1992: Maternal and Child Health Data Book*. Washington, D.C.: Children's Defense Fund, 1992.

Contains background information and data about prenatal care, infant mortality, low birthweight, child health status, immunization, AIDS and other sexually transmitted diseases, insurance, and Medicaid. The report also lists recommendations to ensure the healthy growth and development of all children (52 pages).

National Coalition of Hispanic Health and Human Services Organizations. . . . *And Access for All: Medicaid and Hispanics*. Washington, D.C., 1990.

Serves as a final report of a study of the Medicaid program concerning participation by Hispanic Americans and the ability of the Medicaid program to meet their needs. The report contains overall findings and recommendations and also specific findings for Arizona, California, Florida, Illinois, New Jersey, New York, and Texas (145 pages).

National Commission to Prevent Infant Mortality. *A Resource Directory*. Washington, D.C., January 1992.

Lists federal legislative and executive branch resources; associations of state and local government; national health professional organizations; research, policy, and advocacy organizations; international health organizations; and information clearinghouses (27 pages).

_____. *One-Stop Shopping: The Road to Healthy Mothers and Children*. Washington, D.C.: National Commission to Prevent Infant Mortality, April 1991.

Describes one-stop shopping, a strategy to coordinate and integrate health and social services for children, pregnant women, and families. The report also describes common barriers to services, makes recommendations, and highlights programs in North Carolina, Massachusetts, Florida, Delaware, and New Mexico (39 pages).

National Committee for Injury Prevention and Control. *Injury Prevention: Meeting the Challenge*. New York, N.Y.: Oxford University Press as a supplement to the *American Journal of Preventive Medicine*, Vol. 5, no. 3, 1989.

Provides background and offers recommendations for injuries stemming from traffic, residential, recreational, and occupational accidents and from violence, assaults, child abuse, domestic violence, elder abuse, rape and sexual assault, suicide, and firearms (303 pages).

New England SERVE. *Ensuring Access: Family-Centered Health Care Financing Systems for Children with Special Health Needs*. Boston, Mass., 1991.

Lists criteria for judging health care financing systems from the perspective of children with special health needs in the areas of access, benefits, quality, family participation, and cost containment (27 pages).

Orloff, Tracey M.; Rivera, Lourdes; Harris, Phyllis; and Rosenbaum, Sara. *Medicaid and Early Intervention Services: Building Comprehensive Programs for Poor Infants and Toddlers*. Washington, D.C.: Children's Defense Fund, July 1992.

Describes how states can improve and coordinate services for children with disabilities under Medicaid and Part H of the federal Individuals with Disabilities Education Act. It includes case studies of programs in Louisiana, Massachusetts, Maine, North Carolina, North Dakota, Oklahoma, and West Virginia (133 pages).

Orloff, Tracey M.; Rivera, Lourdes A.; and Rosenbaum, Sara. *Medicaid Reforms for Children: An EPSDT Chartbook*. Washington, D.C.: Children's Defense Fund, September 1992.

Provides results of a 50-state survey to determine states' progress toward implementing major reforms in their Medicaid Early and Periodic Screening, Diagnostic, and Treatment programs. It contains numerous charts that compare state activities and also makes recommendations for improving state programs (140 pages).

Schlitt, John J. *Adolescent Pregnancy in the South: Expenditures and Investments*. Washington, D.C.: Southern Center on Adolescent Pregnancy Prevention, 1992.

Analyzes public spending in 17 southern states to support families begun by teenagers. It contrasts program costs for AFDC, food stamps, and Medicaid with expenditures for adolescent pregnancy prevention (20 pages).

Schorr, Lisbeth B. *Within Our Reach: Breaking the Cycle of Disadvantage*. New York, N.Y.: Bantam Doubleday Dell Publishing Group, Inc., 1989.

Addresses numerous social issues related to at-risk youth, including unplanned pregnancies, prenatal care, child health services, care and education of young children, schools, and populations at highest risk. For each topic area, it provides background and highlights a variety of programs designed to address the problems (398 pages).

Seidel, J. S., and Henderson, D. P., eds. *Emergency Medical Services for Children: A Report to the Nation*. Washington, D.C.: National Center for Education in Maternal and Child Health, 1991.

Provides a history of emergency medical services for children and covers systems of emergency care, education and training for professionals and the public, rehabilitation, injury prevention, quality improvement, data collection and analysis, financing services, and the need for children to have a medical home (168 pages).

Sherman, Arloc. *Falling by the Wayside: Children in Rural America*. Washington, D.C.: Children's Defense Fund, 1992.

Examines the status of children in rural America in the areas of health, education, housing, public assistance, economics, child care, and early childhood education. Each topic area includes background, conclusions, and recommendations (180 pages).

Shuptrine, Sarah C.; Grant, Vicki C.; and McKenzie, Genny G. *Uninsured Children in the South*. Columbia, S.C.: The Southern Institute on Children and Families, November 1992.

Presents state-by-state data about uninsured children in southern states, describes Medicaid expansions and opportunities to insure more children, and provides information about state initiatives to insure more children (90 pages).

Southern Regional Project on Infant Mortality. *The South's Agenda for Healthy Infants and Families*. Washington, D.C., 1991.

Presents a policy statement of the Southern Legislative Summit on Healthy Infants and Families concerning access to care for children and pregnant women, high-risk pregnancies and substance abuse, unintended pregnancies, perinatal providers and medical malpractice, and federal Year 2000 goals. The document also contains model legislation for each of the policy areas (50 pages).

Summer, Laura. *Working Together: A Guide to Coordinating WIC and Medicaid Services*. Washington, D.C.: Center on Budget and Policy Priorities, June 1991.

Provides background on Medicaid and WIC (the Special Supplemental Food Program for Women, Infants, and Children). It describes methods states can use to improve and coordinate the two programs, and displays in chart form which states have adopted a variety of activities to improve their own programs (35 pages).

Rosenbaum, Sara; Hughes, Dana; Harris, Phyllis; and Liu, Joseph. *Special Report: Children and Health Insurance*. Washington, D.C.: Children's Defense Fund, January 1992.

Analyzes national data concerning children without employer-based health insurance coverage. The report includes comparative data for children of different ethnic and racial backgrounds, family income, and parental employment status. It also shows a downward trend in employment-based insurance since 1977 (40 pages).

U.S. Congress, Office of Technology Assessment. *Adolescent Health - Volume I: Summary and Policy Options*. Washington, D.C.: U.S. Government Printing Office, April 1991.

Reviews the physical, emotional, and behavioral health of adolescents in America today, assesses the resources available to adolescents, and discusses the gaps in accessibility and financing of adolescent health services (188 pages).

U.S. Department of Health and Human Services. *Access to Childhood Immunizations: Recommendations and Strategies for Action*. Washington, D.C.: National Vaccine Advisory Committee, April 22, 1992.

Describes the following four major goals related to improving access to immunization services: secure financing adequate to ensure access to immunization services and coverage levels of 90 percent by age two; ensure the capacity to deliver vaccines through an adequate supply of providers and stable public health infrastructure; increase demand for immunization services through family-focused outreach and informing; and monitor immunization coverage levels for children at age 24 months. The report also lists recommendations and strategies for achieving the goals (42 pages).

_____. *EPSDT: A Guide For Educational Programs*, pub. no. 02192. Washington, D.C.: Health Care Financing Administration, September 1992.

Describes the Early and Periodic, Screening, Diagnostic and Treatment Program under Medicaid, discusses how schools can develop or augment EPSDT outreach and health service programs, illustrates different types of coordination between schools and the EPSDT program, and directs readers to additional resources for information (51 pages).

_____. *Healthy Children 2000*, DHHS Publication No. HRSA-M-CH 91-2. Washington, D.C.: U.S. Department of Health and Human Services, 1991.

Lists approximately 170 national health promotion and disease prevention objectives related to mothers, infants, children, and adolescents. About two dozen topic areas include background information and strategies to help meet listed objectives for maternal and infant health, immunization and infectious diseases, nutrition, family planning, unintentional injuries, diabetes and chronic disabling conditions, HIV infection, sexually transmitted diseases, clinical preventive services, alcohol and other drugs, tobacco, mental health and mental disorders, violent and abusive behavior, oral health, and other topics (244 pages).

U.S. General Accounting Office. *Access to Health Care: States Respond to Growing Crisis*, pub. no. HRD-92-70. Washington, D.C.: U.S. General Accounting Office, June 1992.

Reviews state initiatives to expand access to health insurance and control rising health care costs. The report highlights programs or proposals in Hawaii, Massachusetts, Oregon, Minnesota, Florida, Vermont, Maine, Maryland, New York, and Washington. It also discusses federal barriers that limit state options to achieve universal access to health care (84 pages).

_____. *Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children*, pub. no. HRD-92-73FS. Washington, D.C.: U.S. General Accounting Office, May 1992.

Provides information on services, eligibility, and program interrelationships for the following seven federal programs: Preventive Health and Health Services Block Grant; Maternal and Child Health Services Block Grant; Early and Periodic Screening, Diagnostic, and Treatment program under Medicaid; Childhood Immunization Program; Childhood Lead Poisoning Prevention; Community Health Centers; and Migrant Health Centers (32 pages).

_____. *Hispanic Access to Health Care: Significant Gaps Exist*, pub. no. PEMD-92-6. Washington, D.C.: U.S. General Accounting Office, January 1992.

Contains the testimony of Eleanor Chelimsky, assistant comptroller general, before the House Select Committee on Aging and the Congressional Hispanic Caucus, September 19, 1991. It also contains a bibliography of studies on Hispanic access to health care (30 pages).

Wiener, Joshua M., and Engel, Jeannie. *Improving Access to Health Services for Children and Pregnant Women*. Brookings Dialogues on Public Policy. Washington, D.C.: The Brookings Institution, 1991.

Examines several issues related to financing and delivering health services to children and pregnant women, including Medicaid, private insurance, and delivery system reform. The publication reports on and amplifies presentations made at a July 1989 conference sponsored by the Brookings Institution in conjunction with the National Commission to Prevent Infant Mortality (90 pages).

About the Author

Martha P. King manages NCSL's Maternal and Child Health Project. King has written several publications, including *Saving Lives and Money: Preventing Low Birthweight; Maternal and Child Health Legislation: 1991*; and *Medical Indigency and Uncompensated Health Care Costs*. She also has co-authored several publications and articles, including *Americans with Developmental Disabilities: Policy Directions for the States*, "Helping Kids, Helping Families," and "When Drugs Are the Ties That Bind."

Prior to joining NCSL, King served on the staff of the Colorado General Assembly for seven years and spent two years doing tuberculosis control as a Peace Corps volunteer in rural South Korea. She holds master's degrees in social work and public administration and a bachelor's degree in biology and psychology from Swarthmore College. King is married and the proud mother of two healthy kids.

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